# Minnesota Review and Analysis of Trends in Agency Maltreatment Reports

## Final Report

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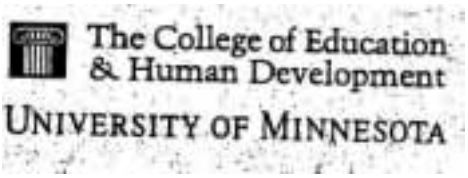


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## Table of Contents

## List of Tables



## List of Figures

## Executive Summary

### Project Overview

In February 2000, the Minnesota Department of Human Services contracted with the University of Minnesota to review and analyze maltreatment reports in Minnesota (with a focus on residential license types), analyze trends in maltreatment reports and dispositions; examine background study results and their relation with subsequent maltreatment; and compare identified trends to other states and national data. This project used summary reports from the DHS Licensing Division, the Department of Health, and Minnesota Statutes to analyze the status of Minnesota's system. Telephone interviews were used to gather information from 11 other states about their maltreatment and background studies systems, and to solicit public reports from those states. A project report was developed by the University of Minnesota to address those questions. This executive summary is organized according to the tasks specified by DHS. It highlights key methodologies, study limitations, key findings and recommendations.

### Project Limitations

This study of the trends in maltreatment reports and staff background studies and set asides has several limitations that must be considered. Limitations included:

- The scope of the current study was limited. It only included selected (primarily residential) license types monitored by DHS. Not all of the reports examined provided information for all selected license types for each year studied. As a result, the interpretations and analyses in the report should be considered preliminary**.**
- While it was within the scope of this project to estimate the rate per consumer for maltreatment allegations and dispositions, the evaluators did not receive information about the number of people in Minnesota who received services in all specified settings for all years studied. This made it impossible to consistently look at trends across all identified Rule types and years. Future comprehensive investigations of trends regarding rates per consumer will require complete information on the number of people receiving services in facilities licensed under the targeted rules.
- The reports reviewed sometimes used the three categories: Rule 42 (MR/RC Waiver funded supports), Rule 203/42_{MR/RC Waiver funded Adult Foster Care), and Rule 203 (Adult Foster Care). Licensing Division staff reported that the use of these categories in monitoring maltreatment and background study data changed over time. For example, beginning 10/1/95, the DHS Licensing Division first began investigating allegations in Adult Foster Care settings ("Rule 203). Until that time, counties were the lead agency for those investigations. Therefore, the 1995 data for Rules 203 and 203/42 are partial year data. Beginning at the end of $1997_t$ a pilot project transferred responsibility for conducting background studies for staff in provider agencies licensed under both Rules 42 and 203 in 12 counties from counties to DHS. This enabled DHS to better identity Rule 203 facilities that were also providing Rule 42 HCBS Waiver services in those counties. Until that time, jointly licensed programs may have been listed under Rule 203 rather than under 203/42. Therefore the Rule 203. category includes some individuals who were also receiving Rule 42 services, especially prior to 1998. These changes affect the accuracy of our estimates of the rates of maltreatment reports and dispositions per consumer in settings licensed under Rule 42, 203 or both since the denominator in the rate is the number of people served in the category. Therefore, the rates reported for Rules 42/203 and 203 should be viewed with caution.

### Key Findings

Task 1 Using data provided by the STATE, summarize trends in maltreatment reports in Minnesota between 1995 and 1998 for adults and children receiving services licensed under the following Minnesota Rules (5,8,18,34, 35,36,38 42,80,203 203/42, and 223, and Nursing Homes).

- The number of maltreatment reports processed by DHS doubled from 1.759in 1993 to 3.204 in 1999,, mostly because of statute changes in 1995 that expanded the role of DHS in reviewing reports involving adult foster care settings. During this time, the number of reports assigned for field investigation

remained steady averaging 606 per year while the number of phone investigations tripled, increasing from 424 in 1997 (the first year this was tracked) to 1,487 in 1999. The proportion of reports found not to involve maltreatment and referred for action to other jurisdictions increased from 10% in 1993 to 65% in 1999.

- DHS completed 4,225 vulnerable adult investigations in studied license types between 1993 and 1998. Of those, 21% involved substantiated maltreatment, 26% were inconclusive, 34% were false and 19% were determined no jurisdiction or no determination will be made. The proportion of VA reports substantiated increased from an average of 19% between 1993 and 1995 to an average of 25% between 1996 and 1998.
- Between 1995 and 1999, of 229 Maltreatment of Minors Act (MOMA) reports investigated by DHS in the investigated rule types, an average of 19% were substantiated. The proportion of MOMA reports substantiated increased from 14% in 1995 to 20% in 1998 (28.3% were substantiated in 1997). However, MOMA reports filed in Rule 3 and other license types serving large numbers of children were not examined so these findings should be viewed with caution.
- The highest rates of substantiated maltreatment for adults were in Rule 34 (1.5 cases per 100 consumers) and Rule 203/42 (1.0 per 100 consumers). The rates were dramatically lower in Rule 18 (0.1 cases per 100 consumers), Rule 36 (0.1 per 100 consumers) and Department of Health licensed nursing homes (0.2 per 100 consumers).
- Overall, the types of maltreatment reported in substantiated cases in the DHS rule types investigated were neglect (51%), physical abuse (16%), sexual abuse (7%), and other (26%). Physical abuse was proportionately more common in Rules 34, 38, 203, 8 and 35 than in other rule types.

Trends over time in the type of maltreatment could not be analyzed for the full set of license types because multi-year data was provided only for Rule 34, 38 and 42. For Rules 34, 38 and 42, the only prominent trend appeared to be a reduction in the number and proportion of cases of substantiated maltreatment categorized as sexual abuse between 1993 and 1997 (declining from 7 cases (9.6% of substantiated cases) in 1993 to 1 case (2.2%) in 1997).

**Task 2 Using data provided by the STATE, summarize trends in the rates of questionable deaths between 1995 and 1998 for adults and children receiving services licensed under the Minnesota Rules (5, 8, 18, 34, 35, 36, 38 42, 80, 203 203/42, and 223; and Nursing Homes):**

- The DHS Licensing Division investigated 35 questionable deaths in licensed provider agencies between 1995 and 1999 (an average of 7 per year). The total number of deaths investigated per year ranged from a low of three in 1993 to a high of 13 in 1997. The majority of investigated deaths (21) involved people with developmental disabilities.
- Most of the investigated deaths occurred among persons receiving services from a provider agency licensed by both Rules 203 and 42 (adult foster care funded by the MR/RC Waiver; 9 deaths), Rule 203 but not 42 (adult foster care not funded by the MR/RC Waiver; 9 deaths), Rule 34 (6 deaths), or Rule 36 (5 deaths). Fewer deaths were investigated in Rule 5 (2 deaths) and in Rule 35 facilities (2 deaths), and one death was investigated in a Rule 18 facility.
- Overall, 14 (40%) of questionable death investigations resulted in substantiated maltreatment determinations, 15 were false, 5 were inconclusive, and 1 was pending.
- Of the 14 deaths involving substantiated maltreatment, only 4 (29%) were caused by the maltreatment. All four deaths caused by maltreatment occurred among persons receiving services from a provider agency licensed under both Rules 203 and 42 (adult foster care funded by the MR/RC Waiver). The other deaths may have occurred even if there had not been substantiated maltreatment.

**Task 3 Summarize how Minnesota's maltreatment reports compare with published reports regarding maltreatment in a minimum of 12 other states with governance similar to Minnesota's, using public reports on rates of maltreatment for children and adults, and background studies available from other state protection state licensing and maltreatment investigations units, and ombudsman offices.**

- While the goal of this task was to find comparable numeric rates of maltreatment, disqualifications and questionable deaths in 11 states, it was not possible to find reports that were directly comparable to the rates reported for the license types investigated for this study. (Reports that were uncovered were provided to DHS. See Table 3.1 for a description of the variability across states in these areas.)
- One of the eleven states (TX) reported that they provide comprehensive public reports regarding maltreatment. A TX task force will finish designing a unified reporting structure across programs in December, 2000. See the full report for further explanation of why we were unable to compare TX reports to the information evaluated for this study.
- Three states (MN, PA & WI) investigate all reports of suspected maltreatment, but none of those states publish comprehensive public reports describing dispositions of all reports coming through the common entry points.
- There was wide variation in processes used to report abuse, neglect and other forms of maltreatment, to collect and use maltreatment reports, in requirements for background studies, and in the use of registries for staff who have a history of substantiated maltreatment.
- Most states provide at least some data to the public through reports or WWW sites for at least some component of their system. However, because of vast differences in how reports are processed, and in the types of settings reported on, these reports cannot be compared directly to Minnesota data without additional data collection and extensive re-analysis that was beyond the scope of this project.
- All but one state required criminal background studies for potential staff.
- Minnesota had seven of 10 key processes regarding maltreatment reporting and background studies in place system wide compared with an average of 4.8 for all states.
- The only key process that was in place in other states that we were unaware of for MN was the use of maltreatment databases to conduct trend analyses for identified issues (a gap this study begins to address).

Task 4 Using data provided by the STATE, summarize the trends in background studies conducted by the Minnesota Department of Health and the Minnesota Department of Human Services for staff providing direct contact services working in programs licensed under the Minnesota Rules (5, 8,18,34,35,36, 38 42, 80, 203 203/42, and 223; and Nursing Homes), between 1995 and 1998.

- Between 1995 and 1998, 327,075 background studies were conducted for people working in **DHS** and MDH licensed facilities.
- The number of background studies conducted varied tremendously depending on license type. The largest numbers of background studies were conducted for nursing homes (165,099), licensed home care agencies (28,244), Rule 38 (15,629), and Rule 34 (16.219).
- The number of background studies conducted per year was highest in 1995 for DHS license types and 1996 for MDH license types (in 1996 all current employees of nursing homes were studied in addition to all new hires).
  Between 1995 and 1998, an average of 1.8% of all DHS background studies and 1.5% of MDH background studies resulted in a disqualification (A total of 5,289 people
- In DHS, the highest disqualification rates occurred for Rule 35 (4.9%); the lowest occurred in Rule 223 (0.6%). All other DHS and MDH programs averaged between 1 and *i%* disqualification rates.
- Of all people disqualified between 1995 and 1999, 62% were disqualified (at least in part) for criminal. behavior, 41 %were disqualified for failure to cooperate with the background study, and only 5.3% were disqualified for serious or recurring maltreatment!

Task 5 Using data provided by the STATE, summarize the set-aside rates for staff background studies conducted for provider agencies licensed under the Minnesota Rules (5,18,34, 36,42,80 and 203) between 1995 and 1998.

- Between 1995 and 1998, 5,289 disqualifications were recorded. In all 1,543 requests were submitted .by individuals asking to have their disqualification set-aside (29% of all disqualifications).

- Between 1995 and 1998, service providers made 135 requests to obtain a variance to employ a disqualified person. 95% of those requests were granted.
  Of 1,543 requests for set-asides, 1,287 were granted (83%) -
- Overall, 24% of all disqualifications were set aside. Overall, 0.39% of all background studies conducted involved people who were disqualified who then had their disqualification set-aside.
- Set-asides were much higher in Rule 35 facilities than for any other license type (1.17% vs. an average of 0.39%).

Task 6 Determine the number set-asides of background study disqualifications followed by subsequent substantiated maltreatment reports between 1995 and 1998. ---------- 3 of 191

- Between 1991 and 1994, a total of 191 disqualifications were set-aside Three people whose disqualifications were set-aside "during those years subsequently engaged in a substantiated instance of maltreatment (a rate of 15.6 per 1,000 set-asides).
- Between 1995 and 1998, a total of 1,287 disqualifications were set-aside. Two people whose disqualifications were set-aside during those years subsequently engaged in a substantiated instance of maltreatment (a rate of 1.56 per 1,000 set-asides). 2 of

Task 7 For each task, describe the analyses conducted, problems and limitations of the data provided, and conclusions that can be drawn.

- Several problems and limitations were noted regarding the data provided. Most difficult to overcome was the lack of population estimates for certain years and certain license types to enable us to generate rates of maltreatment per consumer. Analyses conducted and summary statements about changes over time and difference Between rule are noted within the analysis of Tasks 1 through 6 of this report.

Task 8 For each task, provide recommendations about what needs to be done to test the validity and reliability of the maltreatment data currently collected by the STATE.

- In each section of this report, recommendations for future research are identified. Testing the validity and reliability of the maltreatment data currently collected by the STATE should begin by responding to those research suggestions. In addition to the recommendations reported throughout the report, we recommend several specific strategies to test validity and reliability of maltreatment data including:
- Conduct a series of focus groups, surveys or other information gathering interventions to gather information from county administrators, county case managers, families, consumers, provider administrators and staff and representatives from groups such as Legal Aid, the Ombudsman's Office, and
- v various state agencies about what is working and what is not working in the current maltreatment reporting system and background study system. Review information gathered from some of these groups for the 2000 Minnesota Home and Community Based Waiver Evaluation project to identify areas requiring further exploration. Include in this study a series of in-depth interviews with individuals who process maltreatment reports (e.g., common entry point staff, DHS Licensing Division staff and administrators, data base administrators and analysis personnel) to identify what is working and what changes are needed. Use these sources to answer the research questions posed throughout this report and to verify, revise or discard recommendations made in this report.
- Conduct a systematic study that selects a small number of providers (who provide various types of services) to follow a sample of incidents as they go through the reporting system. For example, this study may follow the first 10 incident reports filed within a set of randomly selected agencies. The goal would be to learn how many and what types of reports get to various stages in the reporting process (e.g., incident report at the agency level, report to the common entry point, referral to DHS licensing, initial disposition by DHS, final disposition by DHS), and what happens to the reports along the way.
- Conduct a study to learn the final disposition of reports sent to DHS by the common entry point but referred to another entity by DHS.

- Conduct a content analysis of one year worth of substantiated reports and one year of reports that were screened out or referred to identify themes in the types of incidents reports and to identify possible training or technical assistance interventions needed by service providers to address recurring or serious issues.

Task 9 To assist the STATE with future policy development, examine and describe what other, similar states are doing, and provide recommendations on what additional data collection and analyses are needed for the STATE have accurate and reliable reports on maltreatment and background studies in residential and other programs.

- Create web based reporting systems. Several states have established web based data collection or reporting systems to track maltreatment reports received, provide access to registries regarding people with substantiated maltreatment, or to share reports on trends and outcomes or maltreatment investigations. Minnesota should investigated potential uses of a web based data system.
- Conduct audits to examine the reliability of reporting systems. Some states conduct regular reliability and validity checks of their reporting systems through external audits. These audits typically are conducted by personnel who are not licensors. The audits use other indicators to determine whether critical incidents that should have been reported as possible maltreatment actually were reported (e.g., provider incident reports, medication error logs, human rights committee logs, household communication books). The goal of these audits is not to finding licensing violations but rather to identify areas where training, technical assistance, or policy changes were needed to improve practices.
- Conduct studies of policy issues or trends. Some states conduct periodic studies examining specific components of their maltreatment reporting system or to examine trends in the content of maltreatment reports received (whether substantiated or not) to identify areas requiring training, technical assistance or policy changes. Minnesota should establish a plan to conduct annual reviews of trends or policy issues regarding maltreatment, questionable deaths or background studies.
- Develop annual reports to the legislature and to the public. Many different strategies were used by the states contacted to report outcomes of maltreatment investigations. Report formats included web based reports, technical reports, fact sheets and searchable databases. As it did with the common entry point report last year, Minnesota should produce an annual report on the status and outcomes of maltreatment reporting, questionable deaths and background studies. The report should summarize outcomes across these areas by population group, age, license type and other policy relevant categories. These reports should include many of the kinds of analyses requested for this project, but with the holes filled in (e.g., the number of consumers in each type of license setting each year).

Task 10 Recommend a process the STATE could use to further evaluate its data collection and analysis practices regarding maltreatment and background studies reporting.

- Stakeholder involvement. Appoint a commission of stakeholders to review reports on maltreatment , investigations, questionable death investigations and background studies and to advise the legislature and the STATE about strengths of the present systems and strategies for improvement in policy, procedure and practice. Conduct a process evaluation of the system that includes in-depth interviews with a wide range of stakeholder groups.
- Data systems and reports. Prepare and disseminate comprehensive annual reports describing initial and final dispositions for all allegations. Include information on all license types. Describe the types of maltreatment, the characteristics of consumers and staff members involved. Put all numbers into context by including the number of people served in each license type examined so rates per consumer can be computed. Similarly when reporting on questionable deaths, future reports should include the total number of deaths occurring among the population studied.
- Coordination across governmental agencies. Develop a management information system that can be used by counties and all state agencies that investigate maltreatment, investigate questionable deaths, and conduct background studies. Investigate what happens to reports whether they are assigned for

investigation, referred to other agencies or screened out. Analyze reports that do not meet the statutory definition of maltreatment to identify trends and issues that should be addressed and corrected. Develop methods to analyze and report on allegations of maltreatment not forwarded to DHS (such as allegations against family members, or allegations that do not involve licensed providers).

- Study the impact of policy changes**.** Examine how changes in statute and policies regarding maltreatment reporting, questionable deaths and background studies affect procedures and outcomes within DHS, MDH and counties. Include interviews with key individuals such as Investigations Unit staff, data collection and analysis staff, other investigative agencies such as the Departments of Health and Children, Families and Learning, county agencies, and other stakeholders in this analysis.

## Introduction/Background

The Minnesota Department of Human Services announced a Request for Proposals CRFP) on August 23, 1999 to review and analyze the trends in maltreatment reports in Minnesota. The purpose of the RFP was to solicit proposals from qualified organizations to review and analyze Minnesota's data on maltreatment in licensed programs. Expectations set forth in this RFP were to review and analyze data collected in Minnesota on maltreatment reports, conduct a trend analysis of the maltreatment data and the disposition results of maltreatment reports; determine any correlation with data on background studies; and compare the identified trends to other states and national data. The purpose of the study was to assist the Department of Human Services (DHS) in understanding the data collected on maltreatment reports, to understand the trends, and to learn how Minnesota's maltreatment report data compares with other states. This report was developed by the University of Minnesota to address those questions and is organized according to the tasks specified by DHS. The tasks for this project were as follows:

**Task 1 Using data provided by the STATE, summarize trends in maltreatment reports in Minnesota between 1995 and 1998 for adults and children receiving services licensed under the following Minnesota Rules (5,8,18,34,35,36,38, 42, 80,203 203/42, and 223; and Nursing Homes), including:**

- The number of reports annually 1995 to 1998;
- The incident rates by license type; and
- The disposition of reports by license type.

**Task 2 Using data provided by the STATE, summarize trends in the rates of questionable deaths between 1995 and 1998 for adults and children receiving services licensed under the Minnesota Rules (5, 8, 18,34, 35,36,38,42,80,203 203/42, and 223; and Nursing Homes), including:**

- The number reports of questionable deaths received each year between 1995 and 1998;
- The rates of questionable deaths by license type; and
- The initial and final disposition rates of reports of questionable deaths by license type.

**Task 3 Summarize how Minnesota's maltreatment reports compare with published reports regarding maltreatment in a minimum of 12 other states with governance similar to Minnesota's, using the following information:**

- Data provided by the STATE;
- Public reports on rates of maltreatment for children and adults, and background studies available from other state protection state licensing and maltreatment investigations units, and ombudsman offices.

**Task 4 Using data provided by the STATE, summarize the trends in background studies conducted by the Minnesota Department of Health and the Minnesota Department of Human Services for staff providing direct contact services working in programs licensed under the Minnesota Rules (5,8,18, 34,35,36,38 42, 80,203 203/42, and 223; and Nursing Homes), between 1995 and 1998, including:**

- The number of background studies conducted for each license type;
- The disqualification rates for each license type;
- The disqualification rates for maltreatment; and
- The number of disqualifications associated with substantiated maltreatment.

**Task 5 Using data provided by the STATE, summarize the set-aside rates for staff background studies conducted for provider agencies licensed under the Minnesota Rules (5,18,34, 36,42, 80 and 203) between 1995 and 1998, including**

- The number of set-asides for each license type;
- The rates of set-asides to background studies for each license type;,
- The number of requests for reconsideration that were received for each license type; and
- The ratio of set-asides to requests for each license type.

**Task 6 Determine the number set-asides of background study disqualifications followed by subsequent substantiated maltreatment reports between 1995 and 1998.**

**Task 7 For each task, describe the analyses conducted, problems and limitations of the data provided, and conclusions that can be drawn.**

**Task 8 For each task, provide recommendations about what needs to be done to test the validity and reliability of the maltreatment data currently collected by the STATE.**

**Task 9 To assist the STATE with future policy development, examine and describe what other, similar states are doing, and provide recommendations on what additional data collection and analyses are needed for the STATE have accurate and reliable reports on maltreatment and background studies.**

**Task 10 Recommend a process the STATE could use to further evaluate its data collection and analysis practices regarding maltreatment and background studies reporting.**

## Methodology

The purpose of this project was two-fold. One was to analyze trends based on summary data provided by the DHS Licensing Division Investigations Unit along with data about nursing homes from the Minnesota Department of Health's Office of Health Facilities Complaints. The primary focus was on residential programs. In the case of MDH, the primary focus was on nursing homes rather than home health care, boarding care, hospitals or temporary health care facilities. Because summary data rather than raw data was provided, statistical analyses procedures were not used (nor were they appropriate). Instead a descriptive analysis of the summary data was conducted. The other purpose of this project was to gather qualitative data through conducting phone interviews with individuals from state agencies, protection and advocacy organizations, and Ombudsman's offices in 15 states other than Minnesota to gather information regarding how maltreatment of vulnerable adults and children was reported, and the extent to which public reports were published about those reports. Reports from the other fifteen states were solicited and reviewed. Copies of these reports were provided to DHS.

### Data Sets

Most of the data analyzed for this report was provided by the Project Officer in the form of existing reports from various sources within the DHS (mostly from the Licensing Division's Investigations and Background Studies Units), or from the Minnesota Department of Health's (MDH) Office of Health Facilities Complaints.

Summary reports from the DHS Licensing Division included:

1. *Investigations Unit Activity Calendar Years 93-97.* This spreadsheet summarizes reports received by the DHS Licensing Division for persons served by agencies with the following licenses (Rules 0, 3, 5, 8,18, 29, 34, 35, 36, 38,42, 43, 80, 203, 223, and 203/42; Psych bed) for each year from 1993 to 1997.

2. *Rule 34 Information Used for Graphs, Data used for Rule 38 Graphs, Data used for Rule 42 Graphs.* These three spreadsheets described investigated reports for the referenced Rule for each year from 1993 through 1997 in terms of disposition (e.g., false, inconclusive, substantiated, other) and type of maltreatment (physical abuse, sexual abuse, neglect, other classification).

3. *Investigations Dispositions 1996, Investigations Dispositions 1997, Investigations Dispositions 1998.* These three spreadsheets included dispositions (false, inconclusive, substantiated (VA), no jurisdiction, maltreatment not determined under the Maltreatment of Minors Act (MOMA), and maltreatment determined (MOMA)) for Rules 0,3,5,6, Psych bed, 8, 18,29, 34,35,36,38,42,43,80, 203, 223 and 203/42.

Summary reports from the DHS Licensing Division, Background Studies Unit included:

4. *Minnesota Department of Human Services Division of Licensing ABS MDH Monthly Report for 01/01/1998 to 12/31/1998 Report # 1, Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1998 to 12/31/1998 Report #1, Minnesota Department of Human Services Division of Licensing ABS MDH Monthly Report for 01/01/1997 to 12/31/1997 Report # 1, Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1997 to 12/31/1997 Report #1, Minnesota Department of Human Services Division of Licensing ABS MDH Monthly Report for 01/01/1996 to 12/31/1996 Report # 1, Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1996 to 12/31/1996 Report #1. Minnesota Department of Human Services Division of Licensing ABS MDH Monthly Report for 01/01/1995 to 12/31/1995 Report # 1, Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1995 to 12/31/1995 Report #1. Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1994 to 12/31/1994 Report #1. Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1993 to 12/31/1993 Report #1. Minnesota Department of Human Services Division of Licensing ABS DHS Monthly Report for 01/01/1992 to 12/31/1992 Report* #i. The MDH report summarized background studies conducted for staff in Hospitals, Boarding Care Homes, Outpatient Surgical Centers, Nursing Homes, Licensed Home Care Agencies, Residential Care Homes, Board and Lodging Facilities, unlicenced facilities, and Temporary Health Facilities. The DHS background studies covered staff working in facilities licensed under Rules 0, 3,4, 5, 6, 8, 18, 22, 26, 34, 35, 36, 38, 42,43, and 80. It also provided information about background studies conducted for "A", AD - Rule 223 adult day care, AF - Rule 203 Adult Foster Care, and TA - Temporary agencies.
5. *Background study statistics -1991.* This report includes summary information with total numbers of background studies, disqualifications and set-asides for 1991. Information on this report is not separated by license type.

Summary reports from the Department of Health included:

6. *Nursing Home Statistics.* This report summarizes, for each year from FY 1995 to FY 1999, the number of cases a) of maltreatment, b) received, c) assigned (maltreatment), d) substantiated (maltreatment), e) unsubstantiated (maltreatment), inconclusive (maltreatment), f) resulting in death (maltreatment), g) resulting in death (substantiated) (maltreatment), h) resulting in death (unsubstantiated) (maltreatment). It also lists the number of disqualifications set aside, set aside with subsequent maltreatment, and the number of staff appealing disqualifications.

Reports containing information for each report of maltreatment (without identifiers) from the DHS Licensing Division included:

7. *Minnesota Department of Human Services: Persons Disqualified, Set Aside, Maltreatment Occurred after Disqualification was Set Aside.* This report provided summaries of each of the five cases in which a person whose disqualification was set aside subsequently maltreated a child or an adult.

8. *Questionable death information.* This information described each of 35 questionable deaths investigated by the DHS Investigations Unit between 1995 and 1999. Information provided included incident date, disposition, culpability, Rule, type of alleged maltreatment, age and disability, a brief description of the death, and information about whether the death was preventable.

9. *Report for Rule x -from 01/01/95 to 01/01/96.* These spreadsheets listed each case of alleged maltreatment in 1995 for Rules 5, 8,18,35,36,80, and 203 (with the identifiers removed). The spreadsheets included information about data received, date of disposition, type of maltreatment alleged, corrective actions taken, and disposition but only for 1995. This set of spreadsheets differentiated between Maltreatment of Minors Act reports and Vulnerable Adult Act reports.

Other background materials included:

10. *Minnesota Statutes 1998, 626.5566 Reporting of maltreatment of minors.*
11. *Minnesota Statutes 1997, 626.557 Reporting of maltreatment of vulnerable adults.*
12. *Department of Human Services, Division of Licensing, Investigations Unit: Guidelines for prioritizing reports for investigation.*
13. *MN DHS Bulletin #97-49-1, July 1, 1997:1997 Legislature changes some background study requirements.*
14. *Report of Vulnerable Adult (VA) Maltreatment Allegations: 1998 Statewide Results.* MN DHS, Aging and Adult Services Division. Beginning January 1, 1990 a copy of each VA allegation is required to be sent to the Aging and Adult Services Division of DHS. This report summarizes information from 83 county Common Entry Points on VA allegations submitted from those counties.

The data provided were translated into a series of worksheets in an Excel workbook which were used to create tables and figures to address the evaluation questions.

Some of the research questions asked about the rates at which certain types of reports were made. To answer those questions, it was necessary to estimate the total number of consumers receiving services from provider agencies licensed by specific rules. Several data sets available to researchers were used to estimate these numbers. For example, the number of people with Mental Retardation or Developmental Disabilities receiving waiver (Rule 42) or ICF-MR (Rule 34) services was estimated from reports prepared by the University of Minnesota for the Residential Information Systems Project based on reports provided to the project by each state (Prouty & Lakin, 1994, 1995, 1996, 1997, 1998, 1999). The Project Officer provided estimates of the number of people served in DTH (Rule 38) settings for 1996 - 1998, and for SILS (Rule 18) for 1994 through 1999 based on information solicited from various DHS staff members. These estimates can be found on Table I.1.

**Table I.1 Estimated number of people receiving various services**

| Year | DTH (38) | SILS (18) | Waiver (42) | | | ICF-MR (34) |
|---|---|---|---|---|---|---|
| | | | Corporate or family foster | Family or own home | Total | |
| 1993 | | | | | | 5,072 |
| 1994 | | 1,598 | 1,768 | 698 | 2,466 | 4,838 |
| 1995 | | 1,598 | 3,477 | 1,212 | 4,689 | 4,455 |
| 1996 | 9,787 | 1,278 | 4,348 | 1,316 | 5,664 | 3,826 |
| 1997 | 10,216 | 1,278 | 4,676 | 1,320 | 5,996 | 3,604 |
| 1998 | 10,447 | 1,484 | 5,190 | 1,321 | 6,511 | 3,804 |
| Average | 10,150 | 1,447 | 3,892 | 1,173 | 5,065 | 4,267 |

The other major data set used to estimate the number of service recipients was a report prepared by the House Research Department in 1998 (Chun, 1998). Estimates from that report are summarized on Table 1.2. The report specifically identified the number of "beds" in each type of licensed facility. As a result these numbers may or may not match the number of people in those settings since not every licensed bed is filled at all times.

**Table I.2 1998 Estimated Number of Service Recipients**

| Rule | Notes | Facilities | Beds |
|---|---|---|---|
| Group homes | | 143 | 3,162 |
| Rule 34 | Non - ICF-MR | 16 | 104 |
| Rule 35 | Chemical Dependency rehabilitation programs | 55 | 1,832 |
| Rule 36 | Residential programs for adults with SPMI | 37 | 890 |
| Rule 35/36 comb | | 4 | 140 |
| Rule 203 | 1-4 residents, 5 if elderly | 3,084 | 9,977 |
| Nursing homes | | 438 | 44,303 |
| Housing with services | Primarily elderly | | 468 |
| Board and Lodging w/special services | 5+ people, MI, DD, CD | 92 | 2,602 |
| Boarding homes | Certified | 39 | 1,752 |
| Boarding homes | Non-certified (4 facilities are Rule 36; others Rule 12) | 27 | 1,262 |

This report also summarizes information from coded interviews with staff from State Agencies, Ombudsman's Offices, and Protection and Advocacy Agencies in 15 states other than Minnesota. A copy of the interview protocol is included in an Appendix. Secondary analysis were conducted using reports provided by various sources in the fifteen states. A document review process was used to describe systems within other states for gathering and reporting data about maltreatment of adults and children.

**Definitions**

This project looked at maltreatment rates for children, persons with MR/DD, adults with chemical dependency, mental health limitations or physical disabilities, and older adults in programs licensed under the Rules listed on Table I.3. Rule 203 - Adult Foster Care was used for both MR/DD and for people with other

disabilities. The rule numbers identified throughout this report refer to a specific type of licensed program managed by the DHS. The names of those programs are listed here.

## Table I.3 Rules, Populations Served and Analysis Caveats

| Rule | Population/ Notes |
|---|---|
| Children | |
| 5 | Residential treatment programs for children with severe emotional disturbance (A waiver allows a few adults to be served in these settings). |
| 8 | Group homes for adolescents |
| MR/DP | |
| 18 | Semi-Independent Living Services (SILS) |
| 34 | Residential programs for persons with MR/RC (ICF-MR) |
| 38 | Day Training and Habilitation Services (DTH) |
| 42 | Residential based Habilitation (Waiver) counts all locations, home, corporate foster care etc. The Licensing Division investigates cases regardless of the site if the alleged perpetrator is a staff person (as opposed to a family member). Family member investigations are handled by the county. |
| 203/42 | Adult foster care settings where waiver funded services are also provided. This category (203/42) was not fully differentiated across reports until 1998. Prior to that year many reports that involved 203/42 settings were classified as 203 settings. On 10/1/95 DHS was assigned responsibility to conduct maltreatment investigations for adult foster care settings. |
| 203 | Adult foster care |
| Adults | |
| 35 | Chemical dependency rehabilitation programs |
| 36 | Residential treatment for adults with severe and persistent mental illnesses |
| 80 | Residential facilities and services for adults with physical disabilities |
| 203 | Adult foster care |
| 223 | Adult day care center |
| NH | Nursing Homes |
| BH | Boarding Care Homes |
| HC | Licensed Home Care Agency |

The definition for maltreatment for the analyses involving the system in Minnesota was based on the definitions in the Minnesota Maltreatment of Minors Act (MOMA) and the Vulnerable Adults Act (VA; which included abuse, neglect and financial exploitation). For this report, a questionable death was defined as one that was investigated by the DHS Licensing Division, Investigations Unit.

The term set-aside is used in this report to refer to instances when a person was disqualified from working in a licensed provider agency because a background study revealed disqualifying activities in the person's past, but that disqualification was set-aside based on an appeals process. Set-asides are specific to the person and to a particular employer and job. The disqualification is not eliminated by a set-aside. The person continues to have the disqualification on their record.

**Limitations**

This study of the trends in maltreatment reports and staff background studies and set asides has several limitations that must be considered. Limitations included:

- The scope of the current study was limited. It only included selected (primarily residential) license types monitored by DHS. Furthermore, not all of the reports examined provided information for all selected license types for each year studied. As a result, the interpretations and analyses in the report should be considered preliminary.
- While it was within the scope of this project to estimate the rate per consumer for maltreatment allegations and dispositions, the evaluators did not receive information about the number of people in Minnesota who received services in all specified settings for all years studied. This made it impossible to consistently look at trends across all identified Rule types and years. Future comprehensive investigations of trends regarding rates per consumer will require complete information on the number of people receiving services in facilities licensed under the targeted rules.
- The reports reviewed sometimes used the three categories: Rule 42 (MR/RC Waiver funded supports), Rule 203/42 (MR/RC Waiver funded Adult Foster Care), and Rule 203 (Adult Foster Care). Licensing Division staff reported that the use of these categories in monitoring maltreatment and background study data changed over time. For example, beginning 10/1/95, the DHS Licensing Division first began investigating allegations in Adult Foster Care settings (Rule 203). Until that time, counties were the lead agency for those investigations. Therefore, the 1995 data for Rules 203 and 203/42 are partial year data. Beginning at the end of 1997, a pilot project transferred responsibility for conducting background studies for staff in provider agencies licensed under both Rules 42 and 203 in 12 counties from counties to DHS. Until that time, jointly licensed programs may have been listed under Rule 203 rather than under 203/42. Therefore the Rule 203 category includes some individuals who were also receiving Rule 42 services, especially prior to 1998. These changes affect the accuracy of our estimates of the rates of maltreatment reports and dispositions per consumer in settings licensed under Rule 42, 203 or both since the denominator in the rate is the number of people served in the category. Therefore, the rates reported for Rules 42/203 and 203 should be viewed with caution.

## Results

Project results are organized by the tasks outlined by DHS. Findings and analysis procedures are described for each task. We also identify questions that arise from the findings and data collection or analysis practices that should be investigated further so that conclusions can be drawn about what the findings mean.

### Task 1 Summarize trends in maltreatment reports in Minnesota between 1995 and 1999 for adults and children receiving services licensed under the following Minnesota rules (5, 8,18, 34,35,36,38 42, 80,203 203/42, and 223; and Nursing Homes).

*a. Number of reports annually 1995 to 1999.*

The total number of maltreatment reports received by the DHS Licensing Division for all rules ranged from 1,759 in calendar year 1993 to 3,204 in 1999 (an average of 3,002 per year)(See Table 1.1). These totals, from the DHS report called *Investigations Unit Activity Calendar Years 93-97,* and *Investigations Unit CY 1999,* summarize reports received by the Licensing Division for persons served by provider agencies with the following licenses (Rules 0, 3, 5, 8, 18, 29, 34, 35, 36, 38,42,43, 80, 203, 223, and 203/42; Psych bed). For 1993-1995 Rule 0 referred to providers who were required to be licensed but who had not yet been licensed. For 1996 Rule 0 referred to Rules 1 and 2 which are DHS licensed but under county jurisdiction for investigation. It also referred to providers who were licensed but not by DHS (e.g., Department of Corrections or MDH). For 1997-1998 psych hospital beds were separated out - they are under MDH jurisdiction.

Based on the *Nursing Home Statistics* report, the number of maltreatment reports received by MDH for Nursing Homes ranged from 389 in FY 1998 to 573 in FY 1996 (an average of 456 per year)(See Table 1.2). The MDH *Nursing Home Statistics* report is the only one used in this study that was based on Fiscal Years rather than on calendar years.

*b. Incident rates by license type*

The number of reports varied widely among the various license types and consumer groups. Data for this analyses came from the report called *Investigations Unit Activity: Calendar Years 93-97.* For children, the number of reports varied from 118 reports for Rule 5 facilities in 1998 to 22 reports for Rule 8 facilities in 1996 (See Table 1.3). For provider agencies licensed to support individuals with mental retardation or developmental disabilities (MR/DD), the number of reports per year varied from 67 reports in Rule 42 in 1996 to 667 reports for Rule 34 group homes in 1996. For adults with other types of disabilities, the number of reports ranged from zero in Rule 80 for 1996 to 239 in Rule 36 facilities in 1996. Finally, the number of reports for provider agencies licensed to provide Rule 223 or Rule 203 services ranged from six reports for Rule 223 in 1996 and to 1,091 in Adult Foster Care settings in 1996 and 1997.

Using these figures, we attempted to compute the number of maltreatment reports received by the Licensing Division per consumer served in various programs (See Table 1.3). Figures 1.5 to 1.7 display the changes in the rate of reports received per consumer for various license types. Figure 1.5 shows a decrease in the rate of reports received by the state for Rule 18, Rule 34 and Rule 38 services per consumer between 1996 and 1998. The rate per consumer in services licensed under Rule 42 was the same in 1996 and 1998, with 1997 rates a little higher.

The rate of reports per consumer could be estimated for eight DHS license types in 1998 (See Figure 1.6). In 1998, for analysis purposes, it was assumed that all reports that were made for Adult Foster Care Settings that provided Rule 42 services were listed in the Rule 203/42 category, and that the remaining reports for Rule 203 were for other population groups. Therefore, the number of people with MR/DD known to be in Rule 42 Corporate or family foster care services was subtracted from the 9,977 who were in adult foster homes so the population for Rule 203 was estimated to be 4,787, and the number in Rule 203/42 to be 5,190. People who received Rule 42 services in their own homes or in their family homes were the population considered under Rule 42 (N = 1,321). Rates could not be computed for Rule 203/42 for other years because this category was not clearly differentiated until 1998. The rate of reports per consumer received by DHS was dramatically lower in services licensed under Rules 18, 38, 42, and 35 (ranging from 0.011 reports per consumer in Rule 18 to 0.047 reports per consumer in Rule 35) than in services licensed under Rules 34, 203/42, 36, and 203 (ranging from 0.098 in Rule 203/42 to 0.148 in Rule 203). Differences in the rate of reports received by the Licensing Division per consumer are substantial.

Questions for Future Study. Further study is needed to determine the reasons for the differences in the rate of reports filed per consumer in various license types. Questions that could be asked are:

- Are there differences in how staff are trained to report incidents in various types of programs?
- Alternatively, for services such as those provided under Rule 18, are the low rates related to the amount of scrutiny of what staff do because of the intermittent nature of SILS services?
- What other factors are related to differences in the rate of maltreatment allegations per consumer in various DHS licensed programs?

*c. Disposition by license type.*

This project examined trends in dispositions of reports received by the DHS Licensing Division by rule and by year. Initial disposition of reports submitted to the DHS Licensing Division were reviewed and compared with those reported by MDH for Nursing Homes. Final dispositions of MOMA reports by rule were reviewed as were final dispositions of reports assigned to investigators under the Vulnerable Adults Act (VA). Finally, a limited review was conducted of reports that were actually determined to be maltreatment to describe the type of incident (e.g., physical abuse, sexual abuse, neglect or "other"). Results from each of these analyses are provided below.

Processing Maltreatment Reports.

There are at least four levels at which for maltreatment reports are processed. The first is what happens when an incident report is filed by a staff person at an individual provider agency. Those incident reports are typically examined by program administrators to determine whether the incident is one that requires submission to

the common entry point as possible maltreatment. By law, all reports that allege maltreatment must be submitted to the common entry point. However, some provider agencies forward every incident report (for injuries and incidents) to the common entry point whether related to possible maltreatment or not, while others submit only those they deem to be possible maltreatment. It was beyond the scope of this project to examine the submission process at the provider agency level.

The second level of disposition occurs when a report is submitted to the common entry point at the county level. Within each county, common entry point workers are required by law to identify the lead agency responsible for following up on the report and to forward the reports to that lead agency. According to the *Report of Vulnerable Adult Maltreatment Allegations: 1998 Statewide Results,* 31% of reports involving maltreatment allegations were referred to MDH, 27% were referred to DHS, and 43% were referred to counties as the lead investigative agency. Of 8,770 reports involving allegations of maltreatment, 1,460 (16.6%) also identified a need for adult protective services related to an incident.

It was beyond the scope of this study to examine disposition practices in counties (Common Entry Points). However, based on information obtained for a different study conducted by the University of Minnesota in which interviews were conducted with DD directors in 22 counties regarding the Home and Community Based Services Waiver program (Rule 42, 203/42), it is clear that a significant number of reports received by counties (either by county case managers or other workers or by the common entry point) about injuries and incidents are not forwarded to DHS for disposition as possible maltreatment.

The third level of disposition for maltreatment reports occurs when the DHS Licensing Division determines whether the report will be:

a) *Assigned* - investigated by the Investigations Unit as possible maltreatment.

b) *Referred* — Reports that do not meet the definition of maltreatment in the Vulnerable Adults Act, and reports that meet the requirement for mandated reporting but are not assigned for investigation and are not considered to be maltreatment may be referred to other state agencies such as the MDH Office of Health Facilities Complaints, local law enforcement agencies, or county human services agencies for licensing action, criminal . action or other action. For 1996 and following, cases not considered to be under the jurisdiction of the state DHS Licensing Division, Investigations Unit (e.g., alleged neglect or abuse of a minor by someone other than staff person from a licensed provider agency) are also reported in this category. Such cases may be processed, investigated, and determined to be maltreatment by a county or another jurisdiction., or

c) *Screened Out* — considered not to be maltreatment and not requiring other follow up action. Certain reports that meet the requirement for mandated reporting are not considered maltreatment and are not assigned for investigation. For example, unexplained injuries, self-abuse and client-to-client abuse reports are not investigated . under certain circumstances (DHS Licensing Division, *Guidelines for prioritizing reports for investigation).*

To decide whether a report will be assigned, referred or screened out, intake workers and senior investigators make follow-up phone calls and reviews of records. The first level of investigation determines whether the report is for a DHS licensed program, whether the incident has been received already, whether the alleged perpetrator has been named in other reports, what licensing reports and maltreatment reports have previously been received for the facility. The second level of investigation involves reviewing the report, calling reporters, facilities and other persons who are involved. The number of calls made for this second level investigation increased from 424 in 1997 to 1,031 in 1998 and 1,487 in 1999. A decision of whether to assign, refer or screen out a report occurs after this information has been processed.

The fourth level of disposition occurs for maltreatment reports that are actually assigned for investigation. For those cases, several different possible determinations that could be made. Under the Maltreatment of Minors Act the possible determinations are: maltreatment determined and maltreatment not determined. Under the Vulnerable Adults Act the possible determinations are substantiated, inconclusive, false, and no determination will be made. For both children and adults there is a possible determination of no jurisdiction. The scope of the present study included only this fourth level of disposition.

**Questions for Future Studies.** Several questions emerged relating to disposition practices that were beyond the scope of this project. Among the most important questions requiring further study were the following:

- To what extent are the reports from DD Directors referring to cases that were not submitted to DHS related to the county's Adult Protection roles? What other factors explain the comments made by those DD directors?

- How do county case managers and other county staff decide whether to forward reports regarding illnesses, injuries or other incidents to the common entry point?
- To what extent are decisions made by county staff about which reports to forward to the DHS Licensing Division affected by possible confusion at the county level regarding who the lead agency is for reports coming from settings that are dually licensed as Adult Foster Care and HCBS Waiver services?
- To what extent are dispositions reported by DHS influenced by reporting practices in provider agencies and in county common entry points? What additional training is needed for county staff related to how reports are to be handled?

Initial Dispositions - DHS Licensing Division

This study examined the initial dispositions made by the DHS Licensing Division, Investigations Unit for all rules. Between 1993 and 1999 this unit received 18,016 reports alleging maltreatment. Of those, 4,243 (24%) were assigned for maltreatment investigations; 5,266 (29%) were screened out; and 7,994 (44%) were referred to other state or local government agencies. In addition, between 1993 and 1995, 149 reports were referred to the Department of Health's Office of Health Facilities Complaints and 286 reports were determined to be outside of the jurisdiction of the DHS Licensing Division.

Figures 1.1 and 1.2 graphically show the initial disposition of reports received by the DHS Licensing Division. Two important overall trends can be observed. First, while the number of reports received nearly doubled between 1993 and 1999, the number of reports assigned to investigators remained steady with a low of 537 reports assigned in 1997 to a high of 661 reports assigned in 1995. Second, the proportion of reports within each determination shifted. The proportion of reports assigned to investigators declined from 36% in 1993 to only 20% in 1999. The proportion of reports referred to other agencies increased from 13% in 1993 to 65% in 1999. The proportion of reports screened out decreased from 45% in 1993 to 13% in 1999.

**Questions for Future Study.** Based on theses results, questions for further study include:

- To what extent was the doubling in the number of maltreatment dispositions between 1995 and 1996 due to the change in the Vulnerable Adults Act which was fully implemented in October 1995? This change shifted responsibility for certain activities from the counties to the state and changed requirements for counties regarding which and how many cases to forward to the state. In 1995, the state also changed its internal procedures regarding which cases would be assigned for investigation. The extent to which the rule change and the internal procedures change accounted for differences in initial dispositions should be further investigated.
- To what extent are the changes due to limited DHS resources (e.g., staff, money) for conducting investigations? When the number of cases received increased, did the criteria shift regarding which cases would be assigned to investigators? Were increasingly more serious incidents considered not to be maltreatment but referred to other jurisdictions? What happened to reports involving serious incidents that were determined not to meet the statutory definition of maltreatment that were referred to other jurisdiction?
- To what extent are the changes due to increases in reporting attributable to the additional attention to maltreatment because the new act added responsibility for investigating adult foster care maltreatment to DHS Licensing and increased training and awareness of the importance of reporting?

**Initial Disposition • Department of Health.**

This study investigated the initial dispositions for all maltreatment reports submitted to the DHS Licensing Division, Investigations Unit. It also examined initial dispositions maltreatment reports for nursing homes which are processed by MDH. Initial dispositions regarding allegations of maltreatment in other types of facilities licensed by MDH were not in the scope of this project. Table 1.2 and Figure 1.3 indicate the assignment, disposition and completion rates for maltreatment cases in nursing homes submitted to the Department of Health. MDH investigated an average of 72% of all reports received for nursing home settings between 1995 and 1999. With the exception of 1996, when 410 cases were investigated, the number of cases investigated per year for nursing homes ranged from 291 to 334 during the years studied.

**Questions for Future Studies.** While it may be important to compare the rate of various types of dispositions within DHS versus MDH, such comparisons are beyond the scope of this project. Such a comparison would either need to compare only license/facility types that were very similar (e.g., Rule 42 vs home health care) or to compare all facility/license types in covered by both agencies including services such as boarding care homes, licensed home care agencies, board and lodging facilities, and residential care homes licensed by MDH. Since this study included several DHS license types but only one MDH license type, comparisons between those agencies should be left as a research question for future studies. Future studies should examine the following questions:

- To what extent do MDH and DHS differ in their initial disposition practices?
- To what extent are differences that may exist between MDH and DHS in initial disposition related to the relative resources available to investigate reports, the nature and severity of reports being submitted, or the extent to which certain types of reports are handled by other agencies?

**Initial Disposition: Variations across DHS License Types.**

The proportion of reports assigned to DHS Licensing Division investigators is shown on Table 1.3. There were dramatic differences between license types in the proportion of reports that were actually assigned to an investigator. Between 1996 and 1998, the percent of reports assigned to investigators varied from 34% for Rule 8 to 9% for Rule 36 services. Among the non-MR/DD services only two license types had fewer than 20% of all reports assigned for investigations (Rule 36 and 223). The other non-MR/DD licenses had assignment rates averaging between 26% and 34% (See Figure 1.9). The rate at which reports were assigned to investigators was lower for all MR/DD license types averaging between 12% and 20% of cases assigned for investigation (See Figure 1.10).

There were also differences across license types in the proportion of reports that were screened out (See Table 1.3 and Figures 1.7 and 1.8). The vast majority of all reports that were screened out were in reference to Rule 34 or 38. A total of 1,640 reports regarding those types of facilities that were received by the state between 1996 and 1998 were screened out. An overwhelming majority of reports that were referred to other agencies came from Rule 203 or Rule 203/42 licensed services. A total of 2,607 reports related to Adult Foster Care settings were referred to other agencies between 1996 and 1998. Licensing Division staff report that no reports regarding adult foster care are screened out. At minimum they are referred to counties because those services are county licensed.

**Questions for Future Studies.** While beyond the scope of the current study, these dramatic differences across license types in how maltreatment reports were initially handled by the DHS Licensing Division bear further investigation. Those studies should investigate the following questions:

- Are the differences due to differences in the types of reports received for different facility types (e.g., client to client abuse, theft of personal belongings)?
- To what extent does the fact that counties license adult foster care settings but the DHS Licensing Unit investigates allegations of maltreatment in them influence the patterns in the number of cases sent to DHS Licensing, and the initial disposition of those cases?

**Disposition of Assigned Reports.**

Three different data sources were used to determine the number of assigned cases that were considered to be substantiated maltreatment. The first set of spreadsheets *(Rule 34 information used for graphs, Data used for Rule 38 graphs, and Data used for Rule 42 graphs)* summarized the final disposition for each investigated report of maltreatment between 1993 and 1995. This particular set did not differentiate between minors and adults and its dispositions were limited to false, inconclusive, substantiated and other. They provided summary numbers rather than detailing the disposition for each case individually.

The second set of spreadsheets, *Report for Rule x -from 01/01/95 to 01/01/96,* described each case of alleged maltreatment in 1995 for Rules 5, 8,18,35,36,80, and 203. These spreadsheets included information about data received, date of disposition, type of maltreatment alleged, corrective actions taken, and disposition for each individual report but only for 1995. This set of spreadsheets did differentiate between Maltreatment of Minors Act reports and Vulnerable Adult Act reports.

rule. Then in 1996, 3/4 of all investigators were newcomers to the unit so the number of cases completed went down as they were getting up to speed in their new roles.

The number of cases completed by DHS investigators increased between 1997 and 1998. The number of substantiated cases in DHS licensed facilities was fairly consistent between 1995 and 1998. However, the number of inconclusive, false or other reports declined dramatically between 1995 and 1997. An exploration of the reasons for these patterns was beyond the scope of this study.

**Questions for Future Studies.** Future study should consider the following questions:

- To what extent was the decline in inconclusive, false or other reports reflective of changes in the types of reports that were actually assigned to investigators across time as the system adjusted to the changes in the VA law made in 1995?
- To what extent is the rate of referrals to other agencies explained by the changes in reporting processes for adult foster care, in which DHS licensing investigated maltreatment, but referred licensing issues back to counties?
- To what extent is the change in the rate due to county practices in handling reports they received?
- A related question that was beyond the scope of this investigation to examine is the average time between receipt of a report and its final disposition. To what extent does the processing time for making a maltreatment disposition influence county behavior? How do the DHS Licensing Division activities interact with county adult and child protection activities to ensure health and safety of people in licensed facilities?

**Trends over time (MDH).**

Between 1995 and 1999, MDH completed investigations of 798 reports regarding nursing homes. Of those reports, 29% were substantiated, 52% were inconclusive and 19% were unsubstantiated. For nursing homes, the number of reports for which determinations were made doubled (from 125 to 274 cases) between 1997 and 1998 and remained high in 1999 (276 cases). The number of VA cases that were substantiated rose fairly dramatically between 1996 and 1999 in nursing homes. Further, cases of maltreatment were substantiated at a higher rate in nursing homes than in DHS licensed facilities (29% vs 21%).

**Questions for Future Studies.** Exploration of the reasons for these differences were beyond the scope of this study. Further investigation should examine the following questions:

- Does the increase in substantiated abuse in nursing homes reflect an increase in reporting in nursing homes, increases in negative media exposure, differences in procedures or interpretations used for determinations, changes in the people conducting the investigations, or an actual increase in the amount of maltreatment in those settings?
- To what extent are cases reported to MDH more likely to involve maltreatment that could be substantiated compared with cases reported to DHS?
- To what extent do investigators in the two departments use different interpretations of the law for substantiating cases?
- To what extent are these differences due to differences in the types of programs looked at? If all MDH licensed facilities were examined, instead of only nursing homes, would these differences still be present?

**Completed investigations by license type.**

Figures 1.19 and 1.20 summarize available information regarding rates of completed investigations and their dispositions per consumer served by a particular license type. Table 1.5 shows information about the number of consumers for only a limited number of years and license types. Therefore this analysis must be considered preliminary pending accurate counts of consumers per license type for other years and other license types. That said, there were some interesting variations in the rate of completed investigations per consumer in different types of service settings. By far, the greatest rate of investigations per consumer is in Rule 34 services, averaging 6.2 investigations per 100 consumers served between 1993 and 1998. Also high were Rule 42 with 3.9 investigations per 100 consumers, and Rule 203/42 with 3.3 investigations per 100 consumers. Conversely the rate was very low

in Rule 18 services (averaging 0.3 investigations per 100 consumers between 1996 and 1998) and nursing homes (0.6 investigations per 100 consumers in 1998).

The "other" dispositions included both "no determination will be made" and "no jurisdiction". It is clear from Figure 1.19 that the vast majority of cases with "other" dispositions were for services licensed under Rule 34 or 42. It was beyond the scope of this study to explore why these differences existed.

**Questions for Future Studies.** Future research should consider the following questions:

- What is the distribution of "no determination" findings versus "no jurisdiction" findings - especially for Rules 34 and 42?
- To what extent does the high rate of "other" dispositions reflect the fact that for adult foster settings, counties have jurisdiction over licensing instead of DHS?
- To what extent are the "other" dispositions for Rule 34 related to client to client violence or thefts?

**Rate of substantiated maltreatment by license type (overall).**

The rate of substantiated maltreatment determinations varied widely across license types. The highest rates were in Rule 34 facilities, with 1.5 cases of maltreatment substantiated per 100 consumers between 1993 and 1998. Almost as high, the rate in Rule 203/42 settings was 1.0 substantiated case per 100 consumers between 1996 and 1998. Very low rates of substantiated maltreatment were noted in Rule 36 facilities in 1998 (1 case per 1,000 consumers), Rule 18 services between 1995 and 1998 (1 case per 1,000 consumers), Day Training and Habilitation Settings (Rule 38; 1 case per 1,000 consumers between 1996 and 1998), and nursing homes in 1998 (2 cases per 1,000 consumers). These findings are based only on one year for many of the DHS license types. A comprehensive analysis would require accurate numbers of consumers for each license type for all years studied.

**Questions for Future Studies.** Additional study is required to examine the extent to which, in the case of adult foster care where counties retain the responsibility for following up on licensing problems, the initial determination process by the common entry point results in county to county variation in the reports forwarded to the DHS Licensing Unit for review and investigation. One way this could be investigated is by comparing the rate of referrals and cases screened out to the total number of reports submitted for each county.

**Trends over time in unsubstantiated maltreatment reports by license type.**

Table 1.5 and Figures 1.21 through 1.28 explore differences in the disposition of assigned cases of maltreatment in several license types. Figures were not included for Rules 5, 8 or 80 because the number of Investigations Unit maltreatment investigations was so small. Data were provided for three Rules covering services to individuals with mental retardation or developmental disabilities across six years (Rules 34, 38 and 42). Most striking about those Rules is the variability in the proportion of cases that were substantiated maltreatment. Across all three rules there was a dramatic increase in the number of investigated reports between 1993 and 1995 followed by a dramatic decrease in the number of investigated reports between 1996 and 1998. These rules differ, however, in the types of determinations made over time. For Rule 34 facilities, the proportion of cases substantiated averaged in the low 20% range between 1993 and 1996, but increased to the upper 30% range in 1997 and 1998 as fewer and fewer "other" and "inconclusive" determinations were made. For Rule 38 facilities, the proportion of substantiated cases ranged froml4% to 27% during the entire period.

In Rule 42 service settings, the number of substantiated cases ranged from 1 to 12 during the six year period. The number of "other" cases, however, varied greatly. According to the DHS Licensing Division, the 116 cases with "other" dispositions in Rule 42 settings in 1995 could be related to the closing of many very old investigations where the final disposition was "no determination will be made." While it appears from Figure 1.24 that the number of dispositions and the number of cases of substantiated maltreatment in Rule 42 settings dropped drastically in 1996, the dramatic change is mostly accounted for by a change in how DHS licensing counted cases. Beginning in 1996, dispositions that involved reports from Rule 42 settings that were dually licensed as 42/203 were reported as 42/203. Before that date, this distinction was not routinely made.

Two other rule types had variations over time worthy of comment. There was a dramatic increase in the number of cases completed (increasing from 78 in 1996 to 206 in 1998) and in the number of substantiated maltreatment cases (increasing from 27 in 1996 to 61 in 1998) in Rule 203/42 (adult foster care funded by the

Medicaid Home and Community Based Waiver program). DHS was not always able to identify if a facility was adult foster care only (Rule 203) or dually licensed as adult foster care and supported living services (Rules 203/42). In 1997, the ability to distinguish between the two was enhanced when facilities dually licensed as 203/42 were specifically identified for the background study pilot project in 12 counties. The growth of maltreatment reports for 203/42 may be explained by this increased ability to distinguish these settings rather than an actual increase in maltreatment reports and substantiations. If there was an actual increase, it was likely partially explained by a 20% growth in the number of consumers in 203/42 settings during this period.

**Questions for Future Studies.** Further investigation would be required to learn the extent to which increases in the number of maltreatment reports for Rule 203/42 are due to an increasing awareness and reporting of maltreatment during this period as licensed programs adjusted to the new reporting requirements. Future investigations should reexamine the trends for Rule 203/42 settings now that the new classification has been in use for a couple of years. If subsequent year's data continues to show differing rates of maltreatment across Rule types that cannot be explained by changes in the number of people served, then the following questions should be considered:

- Are people with similar characteristics who are served in ICF-MR settings at different levels of risk for maltreatment than people in Rule 203/42 settings?
- To what extent do current high staff turnover rates and difficult labor market for replacing those who leave differentially impact maltreatment reporting and the rate of substantiated maltreatment across DHS Licensed setting types?
- Do people who receive services in certain types of programs have greater freedom to take risks and to make personal choices resulting in increase incidents with negative outcomes?

**Changes in substantiation rates over time for Rule 36.**

Finally, there were dramatic changes in the number and types of dispositions for reports about Rule 36 facilities between 1995 and 1998. Rule 36 facilities experienced the greatest decrease in the number of reports that were completed during this period of all the types examined. The total number of cases completed declined from 122 to 11. The number of cases of substantiated abuse or neglect investigated declined from 18 in 1995 to 1 in 1998. At the same time, the number of cases the Investigations Unit received dropped from 239 in 1996 to about 132 in 1997 and 1998. However, the percent of cases referred for investigation by other jurisdictions rather than assigned to a DHS investigator increased from 27% in 1996 to 52% in 1997 and 62% in 1998. While this study asked us to examine the rates of reports per consumer in various license types, reports indicating how many people received services in Rule 36 facilities were not available for any year except 1998. Information about the number of people served in each Rule type each year is critical to understanding whether findings such as this one are due to a decline in the number of people served or to some other factor.

**Questions for Future Studies.** The findings regarding Rule 36 facilities raise several questions that might benefit from further exploration. The number of reports and frequency of maltreatment allegations declined precipitously in Rule 36 facilities in three years. If the number of people served stayed the same then the questions are:

- Did the rate of maltreatment per consumer drop substantially during this time? If so, why?
- Were there differences in reporting practices, in training, or in the types of people served?
- What can other Rule types learn from Rule 36 facilities to reduce maltreatment rates in their settings?

**Types of Substantiated Maltreatment**

The final level of analysis regarding the maltreatment reports is an examination of the type of maltreatment that occurred for reports that were substantiated. Uneven information was provided about the types of substantiated maltreatment. One set of spreadsheets *(Rule 34 information used for graphs, Data used for Rule 38 graphs,* and *Data used for Rule 42 graphs)* summarized the types of maltreatment substantiated for Rules 34, 38 and 42 for 1993 - 1997. The spreadsheets for Rules 34, 38 and 42 only provided information about the types of maltreatment for substantiated cases, not for inconclusive, false or other reports. The report covering 1993-1997

did not differentiate between emotional/verbal abuse, financial exploitation, aversive/ deprivation, self-abuse, client/client serious harm and unexplained injury. Instead these were all lumped into the "other" category.

The other set of spreadsheets *{Report for Rule x -from 01/01/95 to 01/01/96)* provided summary information (without identifiers) about each case of alleged maltreatment in 1995 for Rules 5, 8,18,35,36,80, and 203. These spreadsheets included information about date received, date of disposition, type of maltreatment alleged, corrective actions taken, and disposition but only for 1995. While these spreadsheets differentiated between emotional/verbal abuse, financial exploitation, aversive/ deprivation, self-abuse, client/client serious harm and unexplained injury, for consistency, we combined these types of maltreatment into the "other" category as was done for Rules 34,38 and 42.

A limited analyses was conducted of the types of substantiated reports (See Table 1.6 and Figures 1.29 through 1.35) within and across service types. Overall, for the available substantiated reports, the largest category was neglect, accounting for 51% of all substantiated cases. Sexual abuse accounted for 7% of substantiated cases and physical abuse accounted for 16% of the cases. Twenty-six percent of substantiated cases were in the "other" category - a finding that suggests the need to look at the subcategories more carefully in future work. The majority of physical abuse cases occurred in Rule 34 facilities (between 6 and 17 cases per year). Rules 35 and 36 also had a large number of cases of physical abuse in 1995 (11 and 14 cases respectively). Cases involving neglect occurred in all license types except Rule 80. The largest number of neglect cases were substantiated in Rule 36 facilities in 1995 (72 cases). Other license types with a large number of neglect cases included Rule 34 in 1994 and 1995 (55 and 45 cases respectively), Rule 203 in 1995 (33 cases) and Rule 38 in 1994 (30 cases). Substantiated sexual abuse occurred in all license types except for Rule 18 and Rule 203 (but for Rule 203, DHS did not have responsibility for investigating such allegations until 10/95 so cases occurring before that date are not reflected in these data). The largest number of cases occurred in Rule 5 in 1995 (13 cases), Rule 36 in 1995 (14 cases), and Rule 8 in 1995 (5 cases). None of the other license types reported more than four cases in any one year. As Figures 1.34 and 1.35 show, there was variability in the overall proportion of cases in each category of maltreatment by license type. Substantiated physical abuse was proportionally most common in Rules 8, 35, 34, 38, 5.and 203. Substantiated sexual abuse was proportionally most common in Rules 5, 8, 36 and 42. The only substantiated maltreatment in Rule 80 facilities was two cases of sexual abuse.

**Questions for Future Studies.** These findings raise several questions that extend beyond the scope of this study. Future studies should examine:

- Is sexual abuse more common in facilities serving children than those serving adults with cognitive limitations or are children more likely or able to report sexual abuse? Is sexual activity more likely to be considered sexual abuse for children than for adults in DHS licensed facilities?
- What accounts for differences in the proportion of substantiated cases being of the physical abuse type?
- What does the category "other" related to substantiated maltreatment include, and are there differences in prevalence of various "other" types of maltreatment depending on the type of service?
- What types of corrective actions are taken for each type of substantiated maltreatment report? Do those corrective actions vary by license type or by type of substantiated maltreatment?

A comprehensive analysis of this issue would require review of findings at all levels of reporting (at the provider agency level when incident reports are reviewed and decisions are made whether to forward them to the common entry point; at the county level where the lead agency is identified for incoming reports; at the DHS Licensing Division level when reports are screened; and for assigned reports regardless of final disposition) for all Rules and years.

**Task 2 Describe the rates of questionable deaths between 1995 and 1998 for adults and children receiving services licensed under the following MN rules (5,8,18,34,35,36,42,80, 203).**

This analysis of questionable deaths is based on information provided by the DHS Licensing Division and summarized on Table 2.1.

*a. How many reports of questionable deaths were received each year between 1995 and 1998?*

The DHS Licensing Division provided information about the disposition of investigations of 35 deaths occurring among people served by licensed provider agencies between 1995 and 1999 (an average of 7 investigated deaths per year). Table 2.1 summarizes the information about these deaths in terms of year, incident date, disposition date, days to disposition, disposition, culpability, Rule, type of disability, type of maltreatment alleged, age of the deceased person, and a rating of whether the death was considered preventable. As Figure 2.1 shows, the number of days it took for a final disposition to be recorded for these deaths varied with five dispositions occurring more than a year after the death occurred. Understanding the reasons for the variations in time to disposition was beyond the scope of this study.

Figures 2.2 through 2.5 provide more summary information about these cases. Of the deaths investigated, the majority (21) were among people who had developmental disabilities. The only other group with more than 5 deaths investigated during this time period was people with mental illnesses. The total number of deaths investigated per year ranged from a low of three in 1993 to a high of 13 in 1997. Most of the investigated deaths occurred among persons receiving services from an provider agency licensed by Rule 203 but not 42 (9 deaths), 203 and 42 (9), 34 (6), or 36 (5). The average number of days between a questionable death and the final disposition on that death peaked at 297 days in 1996 and fell to 84 days by 1999. Age of the person at death was reported in only 13 cases. Of those 13, three of the deceased were children (ages 8, 15 and 16) while the rest were adults (ranging in age from 30 to 92).

**Questions for Future Studies.** Future studies should examine the following questions that arise from these findings:

- Why the time between death and disposition varied so widely across time?
- A related question is why most of the dispositions took more than six months to be resolved. Based on a review of the raw data, it appears that in a few cases a completed investigation was reopened at a later date accounting for a couple of the longest investigations. That does not, however, explain the time to disposition in the other cases.

*b. What are the rates of questionable deaths by license type?*

The number of questionable deaths investigated during the five year span is quite small compared to the total number of people who receive services from the provider agencies licensed by DHS. Table 2.2 summarizes the number of questionable deaths investigated between 1995 and 1999, the number of questionable deaths investigated per 1,000 consumers, and the number of deaths due to substantiated maltreatment per 1,000 consumers in 5 years.

One challenge in interpreting the death data was some changes in how Adult Foster Care settings for persons in Rule 42 settings were identified. DHS Licensing reported that their tracking systems did not always differentiate Rule 203/42 from Rule 203 settings prior to the end of 1997. Therefore, differentiations between those categories should be viewed with caution. The rate of investigated deaths per consumer in Rule 203/42 settings was based on the average number of consumers in corporate or family foster care settings funded by the HCBS Waiver between 1994 and 1998. The Rule 203 - 203/42 category estimates the number of consumers as the total number in Adult Foster Care minus the number in Corporate or Family Foster care funded by the HCBS Waiver program.

The number of questionable deaths investigated in the five years from 1995 to 1999 ranged from a high of 4.85 per 1,000 consumers in Rule 36 services to a low of 0.71 per 1,000 consumers in Rule 18 services. As Figure 2.6 shows, the number of deaths per 1,000 consumers involving substantiated maltreatment was highest for Rule 203/42 (1.28 per 1,000 in five years or 0.26 per 1,000 in one year). This number could actually be as high as 1.54 per 1,000 consumer in five years if the DD death in Rule 203 facilities was actually 203/42. No deaths were investigated as being questionable for Rule 8 during these five years. The rate of deaths involving substantiated maltreatment per 1,000 consumers was twice as high in Rule 36, 34 and 203/42 services as in Rule 35 or Rule 203 services. The one year rates for deaths involving substantiated maltreatment ranged from 0 in Rule 18 facilities to 0.206 per 1,000 consumers in Rule 203/42.

The reader is reminded that the rate of deaths due to substantiated maltreatment is the rate in a five year period not the rate per year. Furthermore, only 4 deaths in five years were determined to be due to substantiated

maltreatment (all occurred in 203/42 facilities). In another 10 deaths, maltreatment was substantiated but it was not determined whether the maltreatment caused the death.

**Questions for Future Studies.** This study looked only at deaths in DHS licensed facilities that were investigated because someone alleged that the death was due to maltreatment. It was beyond the scope of this project to conduct further analysis of these deaths. Future studies should examine all deaths that occurred within licensed facilities, compare the rate of deaths in facilities with that of the general population, and review the criteria for what constitutes a questionable death. Subsequent studies should examine how many people died in licensed service settings and what proportion of those deaths were investigated. They should review the criteria used to determine whether a death would be investigated. Future studies should also confirm that the classifications of 203 vs 203/42 on the death tracking report are based on the criteria in use since the end of 1997. Future studies should use firm numbers of people served each year in each of the DHS Licensed rule types so that the rate per consumer can be accurately estimated.

*c. What are the initial and final disposition rates of reports of questionable deaths by license type*

**Deaths in DHS Licensed Facilities.**

The dispositions for the questionable death investigations are shown in Figures 2.7 through 2.11. Figure 2.7 shows that the majority of deaths investigated, and the majority of deaths determined to be due to substantiated maltreatment involved persons with developmental disabilities. The percent of questionable deaths in cases where maltreatment was substantiated was 48% for persons with developmental disabilities, 50% for persons with chemical dependency, 25% for persons who were elderly and 17% for people with mental illnesses.

As Figure 2.8 shows, overall, 40% of all questionable death investigations resulted in substantiated maltreatment determinations, 14% were inconclusive, 43% were determined to be false, and 3% were pending. Referring back to Table 2.1, the nature of the substantiated maltreatment leading to death included neglect of supervision, neglect of or failure to provide health care, and failure to protect a minor. Culpability was attributed to the facility in five cases and to one or more care providers in eleven cases (in two cases both the facility and individuals were considered culpable). As Figure 2.9 shows, the number of cases of deaths related to substantiated neglect or maltreatment was three or four in each year from 1995 to 1998. In 1999, no cases were substantiated but two were inconclusive. The number of cases of substantiated maltreatment associated with death included five for 203/42, four for Rule 34, three for Rule 203 (not identified as 203/42), and one each for Rule 35 and Rule 36.

An attempt was made to determine whether the each of the 14 deaths involving substantiated maltreatment were considered preventable by the investigator. In four cases (29%) the deaths were considered preventable, in two cases (14%) preventability was inconclusive, in 8 cases (57%) it was not determined that the death was caused by the substantiated maltreatment. All four deaths that were due to substantiated maltreatment involved persons with developmental disabilities in foster care settings with HCBS waiver funded services.

**Deaths in Nursing Homes.**

The table called *Nursing Home Statistics* provided some information about deaths in nursing homes. Table 2.3 and Figure 2.11 summarize the information about deaths from that table. Table 2.3 notes the number maltreatment allegations for each year, the number of cases where the maltreatment allegation involved the death of the alleged victim, and numbers of investigated deaths associated with substantiated, unsubstantiated or inconclusive dispositions.

A total of 217 investigations between 1995 and 1999 involved a death. The proportion of maltreatment allegations involving deaths ranged from 7% to 13% between 1995 and 1999. A total of 24 deaths between 1995 and 1999 involved substantiated maltreatment (43% to 67% of dispositions involving a death per year). There is no way to know why the number of dispositions is so much lower than the number of allegations from the data provided. The report does not explain whether the other cases are pending, have been screened out, or mean something else. Significant clarification regarding the accuracy of and meaning of this information is needed before accurate questions or interpretations can be made.

Task 3: Describe how Minnesota maltreatment reports compare with published reports regarding maltreatment in 15 to 20 states with governance similar to Minnesota's.

The Project Officer identified 15 states to be contacted about the types of maltreatment reporting used and public reports that may be available in those states. The U of MN attempted to contact each of the identified states to solicit a description of their reports, processes, related laws and policies and any published information they might have regarding reports and dispositions regarding maltreatment of minors and adults. Information was also obtained regarding policies and procedures regarding staff background studies, the existence of a state registry for people found guilty of maltreatment and whether or not a "set-aside" option existed in those states. The U of MN attempted to contact a) state Protection and Advocacy offices; b) state licensing and Investigations Units; and c) state level ombudsman offices in each state to solicit this information. Four states (CA, SC, ND, NE) could not be contacted within the time constraints for this project or did not provide enough information to summarize the characteristics of their systems. Therefore these findings apply only to the other 11 states.

While the goal of this investigation was to find numeric rates of maltreatment, disqualifications, and questionable deaths in other states to compare to the rates in Minnesota, it became clear very early in the process of contacting other states that comparable data were not publically available in any of the states. Unlike crime statistics reported by the FBI that are based on the same federal statutes throughout the country, each state we contacted had their own definitions of maltreatment, their own processes for reporting suspected maltreatment to authorities and investigating reports, and their own way of describing and reporting the results of investigations to the public. The extent of the differences between states in what and how they report is summarized on Table 3.1.

| Table 3.1 Maltreatment Reporting Processes, Background Studies and Registries Across States | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Reporting Structure/Process** | **MN** | **GA** | **IL** | **IA** | **MI** | **NY** | **NC** | **OH** | **PA** | **SD** | **TX** | **WI** |
| **Reporting Structure** | | | | | | | | | | | | |
| **Reports of maltreatment for adult vs. children are reported to or investigated by different government agencies.** | ◆ | ◆ | ◆ | ◆ | ✓ | □ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ |
| **Reports of maltreatment for adults are reported and followed up by multiple government agencies.** | ◆ | ◆ | ◆ | ◆ | ◆ | □ | ◆ | ◆ | ◆ | ◆ | ◆ | □ |
| **Reporting Process** | | | | | | | | | | | | |
| **Mandatory reporting for children.** | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ | ◆ |
| **Mandatory reporting for vulnerable adults.** | ◆ | □ | ◆ | ◆ | ◆ | □ | ◆ | ◆ | ◆ | □ | ◆ | ◆ |
| **100% of reports get investigated and followed up on.** | ◆ | □ | ✓ | □ | ✓ | □ | ✓ | ✓ | ◆ | □ | ◆ | ◆ |
| **Tracks questionable deaths** | ◆ | ◆ | ◆ | ✓ | ◆ | ◆ | □ | □ | ✓ | □ | ✓ | ◆ |
| **Has a database tracking reports of abuse, neglect and other forms of maltreatment.** | ✓ | □ | ✓ | ◆ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **State systematically uses database to conduct trend analysis for identified issues.** | □ | ✓ | ✓ | ✓ | ✓ | ✓ | □ | ✓ | ✓ | ✓ | ✓ | |
| **Publishes public report regarding incidents of maltreatment.** | ✓ | □ | ✓ | ✓ | ✓ | ✓ | □ | □ | □ | ✓ | ◆ | ✓ |
| **Criminal background studies required for at least most staff providing direct contact services.** | ◆ | ◆ | ◆ | ◆ | ✓ | ✓ | ◆ | ◆ | ◆ | □ | ◆ | ◆ |
| **Similar process to Minnesota "set-aside" exists** | ◆ | □ | ◆ | ◆ | ◆ | □ | ✓ | ◆ | □ | □ | ✓ | ◆ |
| **DSPs found to have committed maltreatment have their names placed in a registry** | ◆ | □ | ✓ | ◆ | □ | ✓ | ◆ | □ | ✓ | ✓ | ✓ | ◆ |
| **Total Number of Processes in place across all systems and agencies** | **7** | **3** | **5** | **6** | **4** | **2** | **4** | **4** | **5** | **1** | **5** | **7** |

◆ Yes - across all systems and agencies related to reporting maltreatment
□ No - not within any systems or agencies related to reporting maltreatment
✓ Partial - within at least one system or agency related to reporting maltreatment

Because of the variability evident on Table 3.1, and in information collected from states via interviews and record reviews, it would be inappropriate to compare the rates of reported or substantiated maltreatment from Minnesota with those reported in other states. For example, the only state provides comprehensive public reports regarding maltreatment is Texas. In Texas, a workgroup is meeting to standardize reporting structures across all agencies involved in investigating maltreatment but a final report has not yet been completed (it is due December 2000). Currently in Texas, each agency involved in investigating reports publishes a separate report. We cannot compare Minnesota's reports to Texas reports, however, because Texas does not separate children and adults in its investigations. In Minnesota, we do not have DHS reports that include investigations of maltreatment for children in foster care (with the exception of children in Rule 203/42 settings). Another barrier to comparing Minnesota to Texas is that this investigation only looked at selected Rules in Minnesota. Like Texas, different agencies (DHS, MDH, the counties) report on different components of the system. It was beyond the scope of this project to look comprehensively at all of Minnesota's Rule types or to summarize the disposition of reports that are handled by counties (e.g.. Child Protection cases).

Another illustration of the difficultly comparing across states can be noted in the row summarizing states where 100% of reports are investigated and followed up on. Only three states reported that they investigated all reports of suspected maltreatment (MN, PA, and WI). However, none of those states publish comprehensive public reports describing incidents of maltreatment. In Minnesota, the only public report that we were given was the report on where the common entry points at the county level referred reports it received.

Beyond the difficulties already noted, there are important differences in statute across states. As a result, what is considered maltreatment in one state may be unsubstantiated, referred or screened out in Minnesota and vice versa. A comparison of rates across states would require a much more comprehensive study with more resources than were available for this study. However, having said that, this study did uncover considerable information about the systems used in various states to process maltreatment allegations and background studies. This information provides valuable insights regarding how Minnesota's maltreatment reporting *system* compares to the systems used in other states. Furthermore, public reports available from other states and provided to researchers will be provided to DHS.

There is a great deal of variation across states in the processes for reporting abuse, neglect and other forms of maltreatment; the processes for collecting and using maltreatment reports; requirements for background studies of staff providing direct contact services; and, the availability of a registry for staff who have been found to have abused or neglected children or vulnerable adults. Interestingly, while there is mandatory reporting of abuse and neglect for children across all states, three states have no mandatory reporting laws for adults. Additionally in almost all states there are different reporting process for children vs. adults. Even with respect to adults, reports of abuse and neglect are made to multiple governmental agencies depending upon the type of service the person receives and the type of incident. Most states also have vastly different screening methods for reported incidents (e.g., some at the provider agency level, some at the county level, some within different state governmental department) and variations in the number of possible dispositions for an incident of abuse or neglect. In some states there are different dispositions for abuse and neglect reported incidents within the various state or county agencies responsible for investigating a report.

Many states collect data and maintain databases in at least one or more of their systems or agencies in which abuse and neglect are reported. However ,with one exception, this database is not integrated across all systems or agencies responsible for tracking incidents of abuse and neglect. All but three states tracked questionable deaths in some manner. Few states have widely available public reports on incidents of abuse, neglect or other forms of maltreatment across all responsible agencies and data collection mechanisms. However, most states produce public reports or maintain WWW sites for at least one agency or system involved in tracking maltreatment of children and adults. Many of these reports are developed for Legislative and advocacy bodies or are directed toward a Commissioner or someone in charge of a specific division of the state government. Many states have efforts underway to integrate their database tracking mechanisms. Some are developing WWW based reporting mechanisms.

Most states require criminal background studies for individuals applying for jobs supporting children or vulnerable adults. Only one state did not require any criminal background studies and one other state only required that these background studies be made for children's services. Three states that required background

studies had no process for allowing an individual who had not passed their background study to request a waiver and two additional states had no process in place for children's services. Three states had abuse and neglect registries for both child and adult services, several had registries for children's services but not for all types of adult services, and three states had no registries at all.

A brief summary of the processes, legislation, policies and issues regarding maltreatment reports and disposition for minors and vulnerable adults is provided for each of the 11 states in the following section. All reports collected, organized by state, have been provided to the project officer.

*a. What public reports on rates of maltreatment for children and adults, and background studies are available from state protection and advocacy organizations, state licensing and Investigations Units, and ombudsman offices?*

**GEORGIA**

The state of Georgia defines abuse and neglect in State Rules and Regulations. There are no mandated reporter provisions for adults. For children, all facility staff members are mandated reporters. The only required reportable incident to the State is when there has been a death of a vulnerable person. Reports regarding deaths are made to the Office of Legal Risk Management which is a newly developed agency (July 1999) and has 13 regional offices. The charge of this agency is to look through previously collected data and to look for trends in data related to deaths such as characteristics of provider agencies, types of incidents, location of incidents and type of disability of the person who died.

The 13 multi-county regions in GA have unique community standards and provisions for reporting and defining abuse and neglect. The regions contract with individual service agencies. Service contracts define provider responsibility in reporting incidents. Should a provider not meet these standards the region could take steps such as not renewing contracts or dissolving contracts with providers.

Although not required for vulnerable adults, reports of abuse and neglect do get reported to various state agencies. The agency responsible for overseeing the reports and conducting a follow up investigation varies depending on the population and the type of abuse. Responsible state agencies include: Long Term Care Ombudsman within the Division of Long Term Care, Office of Regulatory Services, Adult or Child Protection Services within the Department of Family and Children Services, Office of Audits, or the Division of Mental Health, Mental Retardation and Substance Abuse. These agencies attempt to communicate with other via memorandum to ensure they are not duplicating efforts and in some cases they may partner with one another to ensure a thorough investigation is completed. Screening occurs at the regional level before reports come to state agencies. Therefore not all reports are followed up on. Priority is given to reports at the state level that involve serious injury or risk. There is no systematic collection and analysis of the data related to reports of abuse and neglect and no public reports are published.

Criminal background studies are required on potential employees. These background studies are done by local provider agencies. It was unknown by the informants used in this study whether a process for "set asides" exists in this state. There is currently not a registry for staff providing direct contact services in Georgia.

**Attachments:**

Rules and regulations of The State of Georgia: Guidelines on Child Abuse Reporting
Facts From the Georgia Department of Human Resources: Elder Abuse in Georgia

**ILLINOIS**

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In Illinois, the Department of Children & Family Services, Office of the Inspector General and the Department of Public Health are the key agencies responsible for gathering and responding to reports of abuse, neglect and maltreatment of adults and minors. There are mandatory reporting laws for abuse, neglect and maltreatment of both adults and children. The Office of the Inspector General (OIG) is responsible for intake, investigation and disposition of all reports regarding state operated facilities and community group homes (including Home and Community Based Waiver services) serving people with mental retardation, mental illness or

developmental disabilities. The OIG is required to follow up on all reported incidents from state operated facilities. For other service types, investigations are prioritized based on severity. Often these cases are referred out to other appropriate agencies including the state police (with whom OIG has an interagency agreement) and the Department of Licensure and Accreditation. Deaths that occur in agencies under the jurisdiction of OIG must be reported to OIG within 14 days. The nature of the death determines whether or not an investigation is completed by OIG.

The Department of Public Health is responsible for investigating allegations of abuse or neglect in any facility licensed under the Illinois Nursing Home Care Act and includes all other responsibilities of Medicaid and Medicare as required by the Health Care Financing Administration. This responsibility covers individuals who live in nursing homes. Intermediate Care Facilities for [persons with] Mental Retardation (ICF/MRs) and Medicaid certified state hospital beds. Referrals are received by the Department of Public health from three avenues: an "800" phone number report line, agency self-reports, and annual licensing surveys at the facilities. This Department is required by law to follow up on all of the reports that are reported via the "800" phone number. Reports that come into DPH from agencies are screened and prioritized based on the severity of the reported incident. Those that are screened out from investigation are held and looked at again at the next regularly scheduled licensing review. Investigations occur at the regional level by the same individuals/agencies that do licensing reviews.

Incidents of abuse, neglect and maltreatment of minors are reported and investigated by the Department of Children and Family Services (DCFS). However, if the child lives in a licensed facility that falls under the Department of Public Health, the report and investigation are conducted by DPH. If the child is a ward of DCFS, DPH will notify this agency of the reported incident. No additional information about the referral, investigation and database tracking system for children in this state was obtained.

The Office of Inspector General and the Department of Public Health maintain databases regarding reported incidents of abuse, neglect and maltreatment. OIG maintains a database of all reported incidents that are determined to be reportable (e.g. appears to be credible incident, includes enough evidence to substantiate). OIG produces an annual report for the Governor and the legislature. Beyond the annual report, the OIG database is used to informally track trends and issues on an on-going basis. Each year specific trend studies are conducted. For example, in 1999 a trend study was conducted after information in the database indicated that the incidents of reports in state operated facilities increased even though the population in these facilities decreased. The information included in the OIG database regarding abuse and neglect reporting and dispositions is also used to conduct "causal" studies over periods of time designed to identify actual causes of abuse and neglect.

The Illinois OIG conducts annual under-reporting studies. Those studies involve going into state operated facilities (but not for private ICF-MRs or other county services) to look for indications of incidents that were not reported but should have been reported. Each year these under-reporting studies use different data sets or indicators. For example, the most recent study looked at human rights committee notes and cases to determine if any incidents described within the context of a human rights committee should have been reported as an incident of abuse, neglect or maltreatment.

The Department of Public Health maintains a database on every reported incident. This database includes information such as the case number, name, resident name, nature of the allegation, investigation date, and disposition. This data is used to produce an annual report to the legislature on abuse and neglect and is distributed for freedom of information requests. The data is not used to conduct any routine trend analysis.

Agencies under the auspices of both the OIG and DPH are required to conduct criminal background studies for all non professional staff (direct care). For CNAs, this initial background study is usually conducted by the educational institution from which they received their training. Background studies remain good for one year. However, those who remain at the same agency are not required to have the background study completed each year. The background study only has to be redone for people who leave an agency and go to work at another agency and have not had a background study in the past year. DPH will consider a waiver request from an individual who has a criminal background in which they were convicted of a disqualifying crime. These requests are made to DPH by the individual and cannot be made by an agency on behalf of the individual. Once a request is received, the DPH staff check the name against the nurse aide registry and interview the individual who is making the waiver request. OIG does not have a similar waiver request process for the agencies under their auspices. DPH maintains a registry of nurses aides who have committed abuse and neglect. If an individual is found to have

committed abuse or neglect they are entitled to a hearing before their names would be placed on the registry and there is an appeals process. OIG currently does not maintain a registry and if an individual is found to have committed abuse or neglect OIG does not have a mechanism to place their name on the nurses aide registry. However, pending legislation would require OIG to maintain a registry.

Attachments

OIG Annual Report for FY 96

Annual Report of the DHS Office of the Inspector General to the Governor and General Assembly covering Fiscal Year 1999

Nursing Home Care Act Abused and Neglected Long-Term Care Facility Residents Reporting Act

Title 77 Sub Chapter C: Long Term Care Facilities - sections: 300.661 Health Care Worker Background Check, 300.663 Registry of Certified Nurse Aides, 300.690 Serious Incidents and Accidents

Fall 1999 Equalizer - Equip for Equality Protection and Advocacy Agency Report

**IOWA**

Iowa law requires all individuals who provides services to children or vulnerable adults to report all incidents of abuse or neglect. For adults, the Department of Human Services (DHS) and the Department of Inspections and Appeals (DIA) have primary responsibility for responding to and investigating abuse and neglect situations. DHS reviews all cases in the community and maintains a registry of caregivers involved in dependant adult abuse. DIA is responsible for the investigations in all licensed facilities. Child protection would investigate if the victim were a child. Local law enforcement may be involved if the situation involves criminal activity.

A central hotline exists for reporting abuse and neglect of adults. Reports received by the central hotline are screened and passed on to the local level regional contacts. For DHS investigations they attempt to see the person in an hour if it's an emergency and 24 hours if not emergency. In a licensed facility, DIA has 20 days to see the people involved. When DHS receives a report from a licensed facility they turn it over to DIA to conduct the investigation. If DIA get the call first, they contact DHS for a tracking number so that everyone is aware of a case in process. All reports are screened to evaluate whether they are abuse or neglect and to assess the severity and priority of the situation.

Both the Department of Human Services and the Department of Inspections and Appeals maintain data bases regarding reports of abuse, neglect and maltreatment of dependent adults. DHS collects information on reporter characteristics, dependent adult age, ethnicity, gender, previous reports made, perpetrator status, relationship to the dependent adult, perpetrator age, ethnicity, gender, employment status and the action taken by DHS along with their findings. They produce a report for internal purposes which is not made available to the public. This information is used for program planning and to track issues such as under-reporting and over-reporting. They also produce an Annual Report on Dependent Abuse. The DIA collects information about the type of abuse, disposition of the allegation, and the county and agency in which the abuse occurred. They use this information to track issues within and across counties and providers. The annual DIA report does not include much information about reports of abuse and neglect.

Any individual who is providing services to a child or vulnerable adult in Iowa must undergo a criminal background study. Individuals can ask DHS for a waiver of the outcomes of the background study. Factors that are considered for the provision of a waiver include the person's age at the time of the crime, rehabilitation and their perspective on the criminal activity. If the request for a waiver is denied by DHS there is an option for the individual to appeal the decision. There is no mechanism to monitor or to track the number of set asides that are granted. The Department of Human Services maintains a registry of direct support personnel. There is also a nurses aide registry. Unfounded reports are not entered in the registry. Substantiated cases are put on registry for 10 years. Undetermined cases will be on registry for six months. The state is developing an integrated registry on the Web where the provider can enter in a PIN number and access information from multiple registries including the nurse aide, dependent adult abuse registry, professional license registry, sex offender, criminal history etc. There is no formal reporting system for the outcomes of inquiries made into the registry or the criminal background studies. However the capacity exists within their system and a sample report was provided to researchers for this project.

**Attachments:**

Dependant adult abuse: a guide for mandatory reporters—Booklet Iowa Department of Inspections and Appeals Fiscal Year 1999 Criminal and Abuse background Studies/Record Study Evaluations-DHS Central Dependant Adult Abuse Registry Report 1998-DHS Chapter 235B of the Iowa code: Adult abuse-DHS Dependant Adult Abuse Report 1998,1999-DHS

**MICHIGAN**

In Michigan, there are mandatory reporting laws related to abuse and neglect of adults and children. Michigan has a regional system of non-profit Community Mental Health Service Providers (CMHSP). Services vary from crisis hotlines to group homes and other structured forms of services. CMHSPs are managed by Regional Boards which provide policy and procedure based on state requirements. Each region has unique policies and procedures. Reports of abuse and neglect are made to the Department of Consumer and Industry Services (CIS), Recipient Rights or to Adult Protective services. In some cases one incident could be reported to all of these agencies. There is also a Long-term Care Ombudsman's office which investigates abuse and neglect in nursing homes.

Reports are made to regional offices of Recipient Rights. Investigations are conducted at the regional or county level. Results of the investigations are reported to the State Office of Recipient Rights. When a child lives in foster care, hospitals, or institutions and receive public funds, reports are also made to the Department of Consumer and Industry Services (CIS) and/or the Office of Recipient Rights (RR). For children who live at home, reports are made to Child Protective Services which is part of the Department of Family Independence Services. When crimes are committed the local law enforcement must be contacted. The Protection and Advocacy organization in Michigan does independent monitoring and receives reports of incidents including abuse and neglect from various people (consumers, family, staff, etc.).

The Department of Recipient Rights has a database system that tracks the total number of reports and the number of serious injury/deaths and non-serious injuries that occur in state operated developmental disability services and hospitals. They receive information from community mental health service providers regarding the number of allegations versus substantiations of abuse and neglect but this information is not included in the RR database. The information tracked by RR is used by the department to identify trends and issues. The Office of Resident Rights produces an annual report on the status of recipient rights protection in Michigan.

Criminal background studies must be completed for all people who want to work in children services and adult foster care. There is resistance to require background studies for all adult services because of the prohibitive costs for small businesses. As an alternative, the owner of the company is required to have a criminal background study and is required to ensure that the individuals s/he hires are of good moral character as defined by the "good morale character requirements of license applicants" (which is defined in the statute). Once the person is hired, the employer must send a letter to the licensing agency saying that the person they hired is of good moral character. If the person does not meet the good moral character requirements they can petition for these requirements to be waived through a hearing with an administrative law judge. There is a central child abuse registry and a nursing home registry but there is not one for all other types of services for adults.

**Attachments:**

Poster "Summary of Abuse and neglect requirements"
Administrative rules concerning the Good Moral Character requirements of License Applicants
Relevant sections of the mental health code
Instruction for completing Recipient Rights reports
Annual Recipient right report: status of abuse and neglect.
Complaint back-log reports: Bureau of Health systems MI Dept of Consumer and Industry Services

**NEW YORK**

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) has oversight responsibilities for all state operated or funded and regulated facilities and services to people with mental retardation or developmental disabilities. These services have regulations which private and state operated agencies must follow. The regulations require that any allegation of abuse, neglect or exploitation; deaths; unusual incidents or accidents; and criminal behavior committed by or directed to consumers is reported internally to the provider agency and investigated by a specially constituted committee whose function is to make sure that an appropriate investigation has occurred and action was taken to prevent re-occurrence.

These regulations spell out clearly a variety of levels of incidents, accidents and allegations. In addition to conducting an internal investigation, all allegations must be reported to families and the police must be notified if a crime has been committed against a consumer. A variety of external oversight bodies must also be notified and could include the district OMRDD office or the NY State Department of Quality Care of the Mentally Disabled (an independent body set up to oversee treatment and care provided to people with mental disabilities). If any of the external oversight bodies have questions or concerns about the allegation or internal investigation, the Commission of Quality Care and OMRDD can investigate. These external investigations more likely happen for serious incidents. As a result of the investigations providers can lose certification. However, it was reported that any number of incidents could be covered up thus resulting in no investigation occurring.

OMRDD receives quarterly reports from all state operated facilities with respect to serious allegations and deaths but these reports do not include all types of abuse and neglect. A statewide committee that includes public and private providers review this data and analyze major issues or incidents. Occasionally, as a result of these reviews, action alerts are sent out to agencies to remind staff providing direct contact services of certain issues (i.e., choking hazards). OMRDD does not produce any public reports.

The Protection and Advocacy agency (P&A) within New York is responsible for oversight of the mental health and developmental disabilities systems. All deaths that occur in programs within MI or DD systems get reported to the P&A. Once reported they have a triage system of determining which get investigated and which do not. They also receive copies of many of the investigations that have been completed in response to reports of abuse and neglect and they are charged with reviewing the "unusual ones." They have a 1-800 number and get more complaints than they can handle. Because of this they have to make judgments about which complaints they should investigate directly and which ones to play a secondary role on. Internal policies guide them in making these decisions. The P&A does produce public reports on unusual incidents and deaths. Incidents regarding child abuse are followed up in a similar fashion the only difference being they are reported to a different statewide hotline for child abuse.

Individuals who work with children and vulnerable adults are not required to undergo a criminal background study before being hired. However, they are asked to self-report in their application process. There is a central registry that identifies individuals who have been convicted of abuse or neglect of children. There is not a registry for staff providing direct contact services who work with adults.

**Attachments:**

- Watching over the children: A review of 1998 commission activities on behalf of children with mental disabilities (August 1999). NY State Commission on Quality of Care for the Mentally Disabled.
- Watching over the children: A review of 1997 commission activities on behalf of children with mental disabilities (March 1998). NY State Commission on Quality of Care for the Mentally Disabled.
- Watching over the children: A review of 1996 commission activities on behalf of children with mental disabilities (February 1997). NY State Commission on Quality of Care for the Mentally Disabled.
- Watching over the children: A review of 1995 commission activities on behalf of children with mental disabilities (March 1996). NY State Commission on Quality of Care for the Mentally Disabled.
- Watching over the children: A review of 1993 commission activities on behalf of children with mental disabilities (March 1994). NY State Commission on Quality of Care for the Mentally Disabled.
- NY State Commission on Quality of Care for the Mentally Disabled Annual Report 1997-1998.
- Mental Hygiene Law: Article 45 - State Commission on Quality of Care for the Mentally Disabled. Chapter 27 of the Consolidated Laws, Title E - General provisions.
- Part 624 Reportable incidents, serious reportable incidents and abuse. Final agency action effective June 14, 1995. NY OMRDD. Bureau of Program Certification.

- Could this happen in your program? A collection of case studies provoking reflection, discussion and action. 1997 Commissions on Quality of Care for the Mentally Disabled
- A brief report on active programming in state psychiatric centers: Has anything changed? (August, 1996). NY State Commission on Quality of Care for the Mentally Disabled.
- In the matter of David Dix. A report by the NY State Commission on Quality of Care for the Mentally Disabled (November, 1999).
- In the matter of R.H.: A patient at Manhattan Psychiatric Center: A report by the NY State Commission on Quality of Care for the Mentally Disabled (April, 1995).
- Incident reporting and management practices at five NYS psychiatric centers. A report by the NY State Commission on Quality of Care for the Mentally Disabled. (May, 1997).

**NORTH CAROLINA**

In North Carolina, the State contracts with counties and the counties sub-contract with specific providers for services provided to individuals with disabilities. Provider agencies conduct their own internal investigations of all maltreatment reports first and send reports to the Division of Facility Services within the Department of Health and Human Services only if they feel the report could be substantiated. Other agencies may also be contacted or involved including local social service agencies, local law enforcement, Adult Protection/Child Protection and the Governor's Advocacy Council for Persons with Disabilities (which is the Local P&A) in the community run (private) facilities. State-operated services are responsible to conduct their own internal investigations with a defined investigative team made up of the director, two other special advocates, and involvement from the human rights committee. The state-operated service agencies are also required to report to Child/Adult protection through the Department of Social Services at the county level.

The Division of Facility Services Office within the Department of Health and Human Services is responsible for conducting surveys and complaint investigations in health care facilities and agencies through the Licensure and Certification Section, which also manages and directs administrative services and quality assurance to ensure compliance with federal regulations for Medicare/Medicaid certification. This section conducts staff development programs for surveyors to meet Health Care Financing Administration requirements. The Licensure and Certification Section is responsible for investigating all allegations of resident abuse, neglect, misappropriation of resident or facility property, fraud against a resident or facility and diversion of resident or facility, and drug use when the act occurs in a nursing home, hospital, home care agency, adult care home, hospice or nursing pool by unlicensed assistive personnel or unlicensed health care personnel.

The Group Living Section of the Division of Facility Services Office within the Department of Health and Human Services keeps a database of general complaints but does not distinguish which complaints constitute abuse or neglect. No information was obtained as to what this Section does with the data they collect although it was indicated that they do not produce any public reports. There is also no systematic means of tracking questionable deaths within this state although there was some indication that there is currently a legislative effort that would require this in some types of facilities.

The North Carolina Governor's Advocacy Council for Persons with Disabilities (P&A) provides protection and advocacy for people with mental retardation and/or mental health issues. While the majority of their work is done on individual basis, they engage in systemic change efforts through legislative involvement and input on statewide study commissions and task forces. The Governor's Council plays a role in investigating all deaths in the psychiatric hospital system and anytime there is a death with an individual case they are involved with. Major responsibilities related to abuse and neglect include: 1) receiving referrals from any source (e.g., consumers, family members, caregivers, facilities (state and community-based, etc.)), 2) completing an intake, and 3) assigning the case to one of 3 state or 12 field staff who investigate the complaint, determine the facts, and assist the consumers to achieve a fair and just outcome. With abuse and neglect situations, this may mean discussing preventative measures, referring it to other agencies with follow-up, work with their attorneys to develop a lawsuit, and many other remedies. The Governor's Council does not review other agencies' abuse, neglect, deaths investigation on any ongoing basis since they are not a regulatory agency, but do have the authority to review any reports if anyone asks for them or if they believe it is appropriate and necessary.

Criminal background studies are required for applicants who are applying for work in adult care homes, foster care, nursing homes and health care agencies. For individuals with criminal backgrounds consideration is made regarding the person's age at the time of the crime, rehabilitation etc. The Division of Facility Services Office within the Department of Health and Human Services maintains two registries. A Nurse Aide I Registry includes all individuals that meet federal and state training and competency requirements to perform Nurse Aide I activities. The Health Care Personnel Registry is a registry of unlicensed assistive personnel and unlicensed health care personnel who have been accused of or found by the Department to have harmed a resident or a facility through the Health Care Personnel Registry Section. Any person who is accused of abuse or neglect can file a petition for a contested hearing and the finding is not listed on the registry until after the case is heard by an Administrative Law Judge. Rebuttal statements are listed on the registry in addition to the persons name. Before hiring staff to work in facility-based services, in-home, adult care homes, state operated facilities or health care facilities agencies must study to be certain the applicants name does not appear on the registry.

**Attachments:**

GS 131 E, Article 15 (255-256) Nursing Aide and Health Care registry.
GS 131 D Inspection Licensing of Facilities
GS 131D-40 Criminal Record Check Required for Certain Applicants for Employment (Adult Care Homes)
GS 131D-10.3A Mandatory Criminal Check (Child Foster care)
GS Chapter 7B, Article 3, Child Protective Services
GS Chapter 108A, Article 6, Adult Protective Services
State-operated policy statements regarding Human rights committee and abuse neglect and Exploitation of Consumers including Corporal Punishment
Instructions for the Nurse Aide and Health Care Personnel Reporting Guidelines

**OHIO**

In Ohio the process for reporting and investigating incidences of abuse, neglect or maltreatment varies depending upon the type of service an individual receives. Services to adults with various mental health needs in Ohio are provided through state hospitals which are run by the state Department of Mental Health or community-based services governed by County-based Mental Health (citizens) Boards. County Boards are private non-profit boards that in turn contract with private providers. For children, services are primarily offered in the community. If they need hospital services they are provided in a privately run psychiatric hospitals.

Although the state licenses all mental health programs, it only deals directly with abuse and neglect investigation within state-operated services unless the local protocol at the County Board level is exhausted. Within state operated services, abuse and neglect would be reported internally by the person with direct contact to the Client Advocate at the state facility and would, in turn, be directed to the State Office of Quality Assurance within the Department of Mental Health. In addition, criminal charges might be filed if necessary. In such cases, reports are turned over to law enforcement (more typical in abuse situations). In addition to DMH, another state agency, the Ohio Legal Rights Service reviews all state incident reports and does follow-up. In community services, provider agencies are required to report unusual incidents to the state Licensure office and to the Quality Assurance office. However, investigations almost always occur locally unless the situation cannot be resolved in which case the state would get involved.

Community services to people with mental retardation and developmental disabilities are run by 88 County Boards who contract for services with private providers. All person's providing services are required to report any alleged, suspected or actual abuse and neglect to the County Board. For adults who receive services in the community, reports are made to the local law enforcement agency and to the County Board in the county where the incident occurred. For children, reports are also made to the local public children's service agency. If a person resides in a state run developmental center, the report goes to the Department's on Mental Retardation and Developmental Disabilities Developmental Center Office of Registry (DCIRS) as well as the State highway patrol. For MUI (major unusual incidents) or abuse and neglect the all reports must be made to County board within 24 hours and they must be registered through the state (ITS) "Incident tracking system" for community based services. Otherwise they go into the Developmental Center's Office or registry (DCIRS). Ohio is currently working on

developing a single web-based system for both the ITS and the DCIRS. Once the report goes to the Department of MR/DD, they must report it to the Ohio Legal Rights Services and legal guardians must also be notified. In State-Operated services for MR/DD (the 12 state developmental centers) all employees are required to report and the State Department of OMRDD tries to review the reported incident within 24 hours. Children's services are first reviewed by the local county and then reviewed by the state after the reports have been completed.

For people who are aging and receive long term care in nursing homes or in-home personal care services, the Long Term Care Ombudsman -within the Ohio Department of health has an abuse investigation unit that is required to receive and follow up on allegations of abuse and neglect. All facilities are required to report any incident of abuse or neglect. Usually cases go to the LTC Ombudsman who makes sure everyone is informed, perhaps doing an investigation of their own or going into a borderline situation to make a report. They might report to regulatory agencies as well as the Attorney General's Office. Adult Protective Services does not have jurisdiction over long term care facilities. They get involved only if the complaint is about the person living in their own home. If the person is receiving services from a PCA in their own home, the report is usually made to both Adult Protective Services and the Ombudsman. If APS is not responsive to a family abuse situation, the Ombudsman may get involved because they are the place that handles complaint when other state agencies are not providing satisfactory services.

There are multiple ways in which data are collected in Ohio, but the system is not integrated across agencies. There is work in progress to develop a Web-based system to track all incidents of abuse and neglect. OMRDD uses the "Information Tracking System" (ITS) to assess incidents and reports this information back to counties. The Ombudsman office keeps a record of all complaints and uses this information quarterly to identify systemic issues. This information is often used to support legislation. The Department of Health keeps records of reports obtained in facilities. It is unknown whether they produce any public reports or how they utilize this information. There is no systemic means for tracking questionable deaths separate from the reporting system for abuse and neglect.

There are mandated reporting laws for children and adults. Additionally for all services supporting children and adults there is a requirement that a background study be completed prior to hire. There is a provision that considers how long ago the crime was committed, rehabilitation etc. and exceptions can be made. Currently there is consideration to further investigate how many people are denied the opportunity to work in human services and healthcare because of the background study requirement. This interest has been sparked by workforce issues with regard to being able to hire enough people to fill positions. There is no tracking system of the results of these background studies statewide. Currently there is no registry for staff providing direct contact services or nursing aides although this in under development.

**Attachments:**

5123:2-17-02 Packet of Statutes/rules/law regarding the ODMRDD

- Packet from LTC ombudsman and with statutes.
- Data report (LTC Ombudsman or IMBRUED)

**PENNSYLVANIA**

In Pennsylvania, there are mandatory reporting requirements for children and vulnerable adults. Reports are made to various agencies depending on the type of service provided and the type of incident being reported. The Office of Mental Retardation is responsible for overseeing investigations of abuse and neglect. There are 67 counties and 4 regions responsible for the services with state supervision. The counties contact with the provider agencies. Allegations of abuse and neglect are reported by providers to both the county and to the State. Providers have to report all unusual incident reports which include abuse, neglect and exploitation within 24 hours. They also must report fires, any injury or death along with information as to whether or not the police have been called, and significant incidents of client to client violence. Providers are also required to report incidents within 72 hours if there is a need for protective services under the Older Adults Protective Services Act. Often reports should also be made to the Ombudsman when they are in a licensed facility.

Every report investigated to see if substantiated or unsubstantiated. The Regional(County) office reviews the reports to decide who needs to investigate: licensor; program person; the county staff; or maybe several

agencies. The Office of Children, Youth, and Families is in charge of most children receiving any type of service including mental retardation services. If there is a facility or a home with all children under age of 21, complaints are investigated by CYF. The Department of Aging works with other types of boarding homes and nursing homes and gathers similar abuse, neglect and exploitation data regarding these types of facilities. The processes are similar and they all operate under regulations within the Public Welfare Code (just different sections). In addition to reporting to regional offices and state agencies, anybody can report to local adult protection.

The Pennsylvania Protection and Advocacy Agency also has certain responsibilities related to investigating allegations of abuse and neglect. They provide an advocate in each one of the State Operated Centers who has a role to investigate abuse and neglect. These advocates receive calls, and if there is an allegation they might refer it to another agency or investigate it themselves. Additionally these P & A advocates might receive a call from another agency such as the Department of Mental Retardation to work cooperatively in investigating an incident of abuse or neglect. The P & A also gets reports of any death that occurs in an MR center or state hospital which they review and do follow-up on something questionable. Initial reports to the P & A advocates can come to their attention through a variety of sources such as attorneys, staff, families, consumers.

The Office of Mental Retardation collects all information regarding unusual incidents and logs this into a database. They create a monthly report by region related to the types of incidents that are reported. This information is reviewed by a committee and they use it to inform policy and to try to prevent further incidences through the provision of training and information dissemination. They do not produce any public reports.

Every employee who works with children or vulnerable adults are required to complete a criminal background study. There are guidelines for what type of criminal activity excludes you from working in the field. There are no provisions for waivers or exceptions and there are no time limits related to the criminal offense, even for misdemeanors. There are no reports which identify how many people are excluded from employment due to the results of background studies.

If an employee is found to have committed abuse or neglect these case are prosecuted and tried like they would be for all citizens through the police and the local district attorney offices. Certain offenses are required to be reported to the Attorney General's Office. There is a central registry for nurse aides but one does not exist for staff providing direct contact services in non-nursing facilities.

**Attachments:**

- Older adults protective services act—includes criminal background information
- Bulletin on Act 28 of 1995- neglect of a care dependant person
- Bulletin On Preventing , Managing and Reporting unusual Incidents and Deaths.
- Bulletin on mandatory Child abuse and Criminal history Clearances
- Bulletin on Obtaining Criminal Clearances on Prospective Employees

**SOUTH DAKOTA**

In South Dakota there is mandatory reporting for abuse, neglect and maltreatment of children but not for vulnerable adults including people with disabilities and the elderly. People working in licensed facilities are covered by statutes of immunity regarding good faith reporting but general public is not covered.

Reporting of abuse, neglect and maltreatment for children and adults varies with respect to process and outcomes depending on the type of service the vulnerable adult or child receives. Often people with developmental disabilities receive services through Adjustment Training Centers (ATC) which are licensed and funded by the Department of Human Services. Within this type of service instances of alleged abuse, neglect or maltreatment must be reported by the agency in which the person is served to the Division of Developmental Disabilities (DD) within 48 hours of the allegation. The DD Division assesses the situation and determines the action to be taken and reports back to the reporting agency the action that was taken. In all cases, the guardians and advocates are notified. If the incident involves a child, agencies must contact the local child protection unit. Referrals made to the child protection units are investigation if needed. If a crime has been committed, the DD unit must report the incident to local law enforcement. If the allegation presents issues related to fraud, the Medicaid Fraud Unit (part of the Attorney General's office) may be brought in. Incidents investigated by the reporting agencies are not

necessarily investigated by the DD Division. All deaths which occur in community services are considered reportable incidents but are not necessarily seen as abuse or neglect. There is no formal reporting requirement.

For individuals who receive services in institutions and nursing facilities funded through Medicaid, alleged abuse, neglect and maltreatment is reported directly to the state Medicaid Fraud Unit within the Department of Social Services. This office is typically thought of as where you report illegal billing practices but in the state of South Dakota they also are responsible for looking at specific incidences of abuse and neglect. Reports must also go to Dept of Health as the licensing and certification agency for assisted living and nursing homes. The Medicaid fraud unit assigns a program specialist (typically a former law enforcement officer) or an auditor depending on the case to investigate and if necessary to prosecute. The South Dakota Department of Health division may also issue deficiencies depending on the alleged incident. When reports come into this agency they have a duty to follow up on all of them. Each report is prioritized as a one (emergency) or a two (non-emergency). There is no system of tracking deaths that occur within these facilities. For individuals who do not receive services in an ATC, institution or nursing home, incidents of abuse or neglect could be reported by the public to Adult Protection Services of the Attorney General's Office.

There is no systematic means for collecting and using maltreatment, abuse and neglect data reported to the various state departments in South Dakota. When a reports comes into the DD Division, basic demographic information is collected and a written report on each incident is produced. The Division uses the information informally by reviewing agency files for the purposes of quality assurance. Reported incidents that come into the DSS Division on Aging are categorized by incident type (e.g., physical abuse, emotional abuse, sexual abuse, self-abuse, exploitation, self-neglect and abandonment). This agency reported using the standard "9-10 system" for coding and extracting information from their system and produce a report called the SD APS Report. This report is made available to anyone who wants it.

There is no requirement for a criminal background study to be completed on individuals who apply for jobs with children or vulnerable adults. There are two registries that include the names of people who have been found to have committed abuse, neglect or exploitation of children or vulnerable adults. There is a nurse aide registry and a child protection registry. Provider agencies serving adults and children with developmental disabilities have access to the nurses aide registry but not the child protection registry.

**Attachments:**

- SDCL Chapter 22-46, South Dakota Criminal code on abuse, neglect and exploitation of disabled adults.
- ARSD Chapter 67:40:08, Adult Protective Services
- South Dakota Adult Protective Services Statistics, SFY 1999
- Chapter 27B-8 the sections regarding resident's rights and reporting of A/N/E—from DHS

**TEXAS**

There are a variety of services for vulnerable adults and children with special needs in the state of Texas. The type of service provided to an adult or child determines which branch of the government has authority to collect and investigate reports of abuse, neglect or maltreatment. Most of the services are licensed under the Department of Health (e.g., hospitals, private psychiatric, medical) or the Department of Human Services (e.g., nursing homes, personal care homes, adult day care, ICF/MR). The Texas Department of Mental Retardation and Mental Health (TDMRMH) is responsible for oversight of services to people with mental retardation and mental health issues but delegates it's authority and responsibility for the planning and provision of services to the Local (regional) authorities, which in turn contract with agency providers to provide community based services. The Department of Protective and Regulatory Services is responsible for the collecting reports of abuse, neglect and maltreatment for all state operated programs, ICF/MR that contract with TDMRMH, community centers, daycare centers, registered family homes and group day homes. There are a number of memorandums of understanding between different agencies to help clarify who is responsible for which services to people with disabilities or other vulnerable people such as children and the frail elderly. The time frames in which investigations must occur for each of these governmental agencies varies depending upon the type of reported incident and whether or not the person is in a facility.

Most abuse, neglect and exploitation is reported to the Department of Protective and Regulatory Services at a 1-800 24 hour number. All reports get some form of investigation. However, DPRS may delegate the investigation to be completed by DHS or DOH staff. In some cases a referral may be made to the Attorney General or to local law enforcement agencies. Depending upon the situation, DPRS may have face-to-face contact or they may delegate the immediate investigation to individuals within the agencies in which the incident occurred (these individuals have received specialized training).

Although DPRS is a main contact for most abuse situations, there is no centralized repository for the collection of abuse, neglect and maltreatment data. Currently a workgroup consisting of representatives from the involved agencies are meeting to standardize the reporting structure between all agencies when reporting abuse, neglect and exploitation issues. A report from this workgroup is due December 15*, 2000. Currently, each agency tracks several data points for their own internal purposes as well as to send information to the Legislature. Across these agencies, basic information is obtained regarding the name of the client, name of perpetrator, date, time location of the incident, injuries, medical treatment, class of abuse, and investigation results. The TDMRMH uses their data to set performance measures for contracts with community MRMH centers and state facilities. The DHS looks at trends and patterns regarding deaths.

The DPRS checks the criminal background of staff providing direct contact services prior to employment and will obtain criminal conviction records for the following facilities that are required by law to request criminal conviction records on prospective employees:

(1) a nursing home, custodial care home, or other institution licensed by the Texas Department of Health under Texas Civil Statutes, Article 4442c;
(2) a personal care facility licensed by the Texas Department of Health under Texas Civil Statutes, Article 4442c or Article 4442c-4;
(3) a home health agency licensed by the Texas Department of Health under Texas Civil Statutes, Article 4447u;
(4) an adult day care facility or adult day health care facility licensed by the Texas Department of Health under the Human Resources Code, Chapter 103;
(5) a facility for the mentally retarded, licensed by the Texas Department of Health; and
(6) an unlicenced attendant care agency that contracts with the Texas Department of Protective and Regulatory Services.

a. A facility may offer temporary employment pending the results of a criminal conviction check. The facility may offer permanent employment after 45 days if it has not received notification of a bar on employability. Facilities must provide to PRS the required information on a job applicant no later than 72 hours after the hour when the person accepts temporary employment.
b. Facilities must provide to PRS the following information: complete name, maiden name, aliases, date of birth, race, sex, social security number, and date hired. The information must be submitted on designated PRS forms. PRS may require applicants to provide their fingerprints.
c. The Texas Department of Health will implement the Nurse Aide Registry, which may be used to satisfy the requirements of a criminal conviction check for nurse aides only.
    (1) PRS will provide the criminal conviction information for the registry. Information contained in the registry will be released to the requesting entity and, upon any subsequent request, to other authorized entities. Authorized entities include facilities listed in subsection (a) of this section, nurse aide training programs approved by the Texas Department of Health, and any organization that provides temporary nurse aides to a facility listed in subsection (a) of this section.
    (2) Facilities listed in subsection (a) of this section must begin criminal conviction checks on prospective employees on September 1, 1989.

Once a background study has been completed, in most cases there is a prohibition to employ the person if they have committed a disallowable crime in the past. However there are some exceptions through waivers that can be granted to medication aides. If a staff providing direct contact services person is found to have committed abuse, neglect or exploitation of an adult or a minor their name may be placed on a registry depending upon the type of agency in which they work. If they are a nurses aide the DHS is responsible to review and investigate all allegations and if a nurse is found to have committed abuse, neglect or exploitation then s/he is entitled to a hearing. If the allegation is not overturned during this hearing the persons name is placed on the nurses aide

registry. The individual may then request an appeal. Texas MRMH has their own internal registry but the names placed on this registry are only shared with human resource staff within state operated services.

Attachments:

- Texas Administrative Code (TAC)
- Title 25 Part 1 TX Department of Health
  - Chapter 134-Private Psychiatric Hospital sand Crisis Stabilization Units
- Title 25 Part 2 TX Department of Mental health and Mental Retardation
  - Ch 404—Protection of Clients and Staff
  - Ch 414 Protection of Individuals and Individual rights (subchapter K)-Criminal history Clearances
- Title 40 Social Services and assistance
- Title 40 part 1 -TX Department of Human Services
  - Chapter 48- Subchapter A-Community Care for the aged and the disabled—Definitions
  - Chapter 72 Memorandum of understanding with other State Agencies
  - Chapter 76—Criminal History Check of Employees in Facilities for Care of the Aged and person's with Disabilities
  - Chapter 90 Intermediate Care Facilities for persons with mental retardation or related conditions—Subchapter G-Abuse Neglect and exploitation: complaint and Incidents reports and investigations
  - Chapter 92 Personal care facilities Subchapter F-Abuse Neglect and exploitation: semi-complaint and Incidents reports and investigations
  - Chapter 94 Nurses aides- Registry finding and inquiries; requirements for Criminal Conviction Checks of Nurse Aides and Trainees.
  - Chapter 95 medication aides- Program requirements
  - Chapter 98 Adult Day care and Day Activity and health Service Requirements—Abuse and neglect and exploitation: complaint and Incidents reports and investigations
- Title 40 part 19 -TX Department of Protective and Regulatory Services
  - Chapter 740, Subchapter E- Criminal Conviction checks of employees in certain facilities servicing the elderly or disabled.
  - Chapter 744-Ombudsman Services

**WISCONSIN**

In Wisconsin, reports of abuse and neglect are primarily handled by Bureau of Quality Assurance within the Department of Health and Family Services. However other agencies have some responsibilities as well. The Department of Human Services is responsible for addressing all complaints that come under the jurisdiction of administrative rule HSF-94. They are responsible for obtaining reports related to patient rights and grievance procedures for people with mental illness, developmental disabilities or substance abuse issues irrespective of where they live and irrespective of their age. Most of their cases are not directly related to abuse, neglect and maltreatment but more related to the appropriateness of the services a person is receiving. Reports of abuse, neglect and maltreatment that come into DHS are referred to the Bureau of Quality Assurance within the Department of Health and Family Services which is responsible for gathering and reporting all information related to abuse and neglect within Wisconsin. The Division of Child and Family Services is responsible for collecting and responding to all incidents of abuse and neglect for minors.

The Bureau of Quality Assurance in the Department of Health and Family Services requires that all provider agencies do an internal abuse and neglect investigation to determine if it has to be reported to BQA. These agencies are provided with guidelines to follow in making the referral decision (e.g., know who likely did the abuse or neglect or know who might know who did it or if there is evidence the incident occurred and it meets the definition of caregiver misconduct). Deaths are considered reportable to BCQ if there is suspicion of abuse or neglect by the caregiver. Agencies do not have to report all deaths to BQC but may have to report to someone else within the overall Bureau. Reports must be reported to BQA within a certain time frame (e.g., nursing home and ICF/MR within five working days, other entities within 7 calendar days). The Bureau of Quality Assurance is

responsible for the following types of services: emergency mental health, community mental health, developmental disabilities, alcohol and other drug addictions, community residential, residential care apartments, rural medical, nursing homes, ICF/MR, home health, and hospitals. Once an incident report is reported to BQC it is screened to determine whether further investigation is required. Intake workers go through report and contact the reporting entity if needed. All reports get entered into a data base whether they are screened out or not. Reports are tracked and monitored so that if a similar report comes in, the information is in the system and intake workers can see if there were previous incidents. If the intake worker determines that the report needs to be investigated, letters of notification are sent to the alleged perpetrator and to the agency. The investigator may do a desk or an in-person investigation. Sometimes BQC may need to make referrals to other agencies, for example if the alleged perpetrator is a credentialed staff person (RN, MD), the report gets forwarded to Department of Regulations and Licensing who is responsible for all professional staff. Another example might include a referral to the Department of Justice where they determine if criminal charges need to be made. Once the investigation is completed the cases are reviewed by a supervisor and then the supervisor forwards those that need to be substantiated to the Office of Legal Counsel. They make final determination and the caregiver is notified and allowed time to appeal decision. If they don't appeal or lose an appeal their name is listed on the registry.

The Bureau of Quality Assurance maintains a database with the following elements: 1) all allegations, 2) types of incidences abuse, neglect or misappropriation plus a brief descriptions, 3) types of agency the person receives services from, 4) vulnerable adult contact information, 5) perpetrator contact information and 6) dispositions. This data is used internally to develop policy and to look for trends. If advocates or other entities ask for a specific report it will be made available. There are no public reports developed or disseminated regarding this data. The Wisconsin Department of Health and Family Services publicly reports incidents of elder abuse in a report called: "Elder Abuse Reports up in 1998." This report includes the numbers of suspected cases reported to the DHFS, number of fatalities involved and the number of situations that were reported to be life threatening.

Wisconsin mandates reporting of abuse and neglect for both children and adults and there is a Caregiver Registry. An individual caregiver who works as a nurse aide, home health aide, hospice aide or other non-credentialed direct care worker who have a finding attached to their name for abuse, neglect or misappropriation of a resident's property will have their name added to this list. The report is generated quarterly and is public information - www.dhfs.state.wi.us/rl_DSL/Publications/NabMisRpt.htm

***b. How do the public reports available from other states compare with reports provided for this project by the state of Minnesota?***

There is tremendous variation among the states reviewed with respect to their processes for reporting, investigating and disposing of reports of maltreatment. The variations in the definitions of abuse, neglect and other forms of maltreatment coupled with vast differences in reporting requirements and available data make it inappropriate to compare actual numbers of reported, investigated and disposed of incidents across states (including Minnesota). Furthermore, the scope of this project did not include gathering comparable information about Minnesota's system. There were however important policy and procedure differences that were uncovered that can be shown. Table 3.1 compares differences across states with respect to their processes and report availability.

***c. How do the number and** types of **maltreatment reports in MN compare with the number and types of reports in other** states?*

See note for Task 3b.

**Task 4: What are the trends in background studies conducted by the Departments of Health and Human Services for staff providing direct contact services working in programs licensed under the following MN rules (5, 8,18,34, 35,36,38 42, 80,203 203/42, and 223; and Nursing Homes) between 1995 and 1998?**

The reports for 1995 through 1998 titled *Minnesota Department of Human Services, Division of Licensing, ABS MDH Monthly Report* and *Minnesota Department of Human Services, Division of Licensing* ***ABS***

*DHS Monthly Report* provided the data to respond to this set of evaluation questions. There was one report of each type for each year. The Minnesota Department of Health report summarized studies conducted for staff in Hospitals, Boarding Care Homes, Outpatient Surgical Centers, Nursing Homes, Licensed Home Care Agencies, Residential Care Homes, Board and Lodging Facilities, unlicensed facilities, and Temporary Health Facilities. The DHS report provided information about Rules 0, 3,4, 5, 6, 8, 18, 22, 26, 34, 35, 36, 38, 42, 43, and 80. It also provided information about background studies conducted for "A", AD - Rule 223 adult day care, AF - Rule 203 Adult Foster Care, and TA - Temporary agencies. No description of what services were included in the "A" category was provided.

Both sets of reports described background study results. For each background study resulting in disqualification, the report summarized disqualifying characteristics as failure to cooperate (reasons 71 to 73), Maltreatment (reasons 68-70) and crime (reasons 1-67) and then provided a total number of disqualifying characteristics for each Rule for each year. The report also summarized the number of reconsiderations requested by individuals along with the number that were granted, and the number of variances requested by facilities along with the number granted. It also reported the number of fingerprints that were required. Finally the report described the disposition of each background study. Those dispositions were classified as ok, disqualified and still in process.

This analysis of these reports focused on a subset of the facility types including services licensed by DHS under Rules 5, 18, 34, 35, 36, 38,42, 203, and 223, as well as MDH licensed Boarding Care Homes (BH), Nursing Homes (NH) and Licensed Home Care Agencies (HC).

*a. How many background studies are conducted for each license type?*

Table 4.1 and Figures 4.1 through 4.4 summarize the number of background studies conducted each year by DHS and MDH. Overall, between 1995 and 1998, 327,075 background studies were conducted for people working in settings licensed under the rules examined for this study. Of that total 92,560 were conducted for DHS licensed facilities and 234,515 were conducted for MDH licensed facilities. As the Figures show, there was tremendous variability in the number of background studies conducted depending on license type and year. For DHS, the number of background studies varied from 1,907 for Rule 203 to 28,344 for Rule 34. The three largest

• programs for persons with mental retardation accounted for a large majority of background studies conducted (28,344 for Rule 34, 15,629 for Rule 38 and 16,219 for Rule 42). Among the MDH programs, 8,045 background studies were conducted for Boarding Care Homes, 165,099 for Nursing Homes, and 65,196 for Licensed Home Care Agencies. The variability across time was just as striking. In DHS programs the number of background studies was highest in 1995 (30,403) and lowest in 1997 (16,564). In MDH programs, only 7,484 background studies were conducted in 1995. Background studies for staff in MDH programs were not conducted until 10/1/95. The number of background studies jumped to 128,497 in 1996 when all MDH current and new employees were studied before tapering to around 50,000 for 1997 and 1998 when background studies were only conducted for employees new to the facility. On 7/1/99 the law changed again so that for nursing homes and boarding care homes all employees, not just direct contact staff, had to have a background study.

In interpreting these findings it is tempting to say that they indicate how many staff work in various types of settings. But that is an inaccurate assumption for a couple of reasons. First, a background study is conducted every time a person is hired by a new provider agency. Since staff turnover rates range between 35% and 75% for the programs described, and since 50% of all new hires have worked in another provider agency prior to their current job (sometimes in many other provider agencies), the counts include multiple background studies conducted for some staff members. Furthermore, the frequency of background studies varies for current employees.

' Before 10/1/97, depending on license status, background studies were conducted for current employees every one, two or more years when the license is renewed. After 10/1/97 existing employees do not have to have repeat background studies. Instead, DHS receives notices of convictions from the Department of Corrections regarding criminal convictions for current employees. It would be necessary to generate an unduplicated count for this system to accurately identify the total number of staff working in various types of programs. That said, the variability across license types does provide an approximation of the relative numbers of staff working in various settings with the largest staff complements working in nursing homes and licensed home care agencies followed by

services licensed by Rules 34, 38 and 42. The variability across time is likely due to policy changes regarding who must have a background study completed and when.

*b. What are the disqualification rates for each license type?*

Between 1995 and 1998, an average of 1.8% of all DHS background studies and 1.5% of all MDH background studies for the programs studied resulted in a disqualification decision. Figures 4.5 through 4.8 show how those rates varied across program types. In DHS programs, the highest disqualification rates occurred for Rule 35 chemical dependency programs (4.9%). The lowest rate is for Rule 223 Adult Day Care programs (0.6%). Other DHS programs had disqualification rates averaging between 1 and 2%. Similarly the disqualification rates for the three MDH programs ranged from 1.6% to 2%. There were notable variations in disqualification rates over time. In most programs regardless of type, the rate of disqualification was higher in 1997 and 1998 than in 1995 and 1996. Since the policy required background studies to be conducted for all current workers in 1995 or 1996 but not after 10/1/97, the lower disqualification rates in those years would reflect the relatively lower likelihood that a successful current employee had a disqualifying event compared with employees new to provider agencies or to the industry.

The one data point that seems more extreme than would be expected under that hypothesis is the 11.1% disqualification rate for Rule 203 settings in 1997. In that case, the higher rate is simply due to the fact that only nine background studies were reported as having been completed in 1997. The explanation given for this is that officially, DHS didn't start conducting background studies for 203/42 settings until 1/1/98. At that time, 12 counties joined a pilot project in which new staff in Rule 203/42 settings had background studies conducted by DHS instead of by the county. For the other counties Rule 203/42 background studies are still conducted by the county.

*c. What are the disqualification rates for maltreatment? How many disqualifications are associated with substantiated maltreatment?*

Between 1995 and 1999 5,289 people were disqualified for 5,937 reasons (a person could be disqualified for more than one reason of the listed reasons). Of those, 313 people were disqualified based on having a record of previous maltreatment (See Table 4.2). The number of people disqualified for maltreatment was lowest in 1995 (24 people) and grew each subsequent year (to 105 people in 1998). Of all people disqualified between 1995 and 1999, 62% were disqualified for criminal behavior, 41% were disqualified, at least in part, due to failure to cooperate with the background study, only 5.3% were disqualified, at least in part because of past maltreatment (See Figure 4.10).

As Figures 4.10 and 4.11 demonstrate there was considerable variability across program types in the proportion of disqualifications due to maltreatment, and the number of disqualifications involving maltreatment. The lowest proportion of disqualifications due to maltreatment were lowest in the MDH programs (Boarding Care Homes, Nursing Homes and Licensed Home Care Agencies) and DHS licensed Rule 223 programs. The highest rates were for Rule 203 (23%), Rule 42 (22%) and Rule 18 (19%). Other residentially based services such as Rule 5, Rule 35, Rule 36 and Rule 34 had disqualification rates due to maltreatment that were at or below 10% as were the rates for the DTH or adult day care settings. In raw numbers, the number of people disqualified for previous maltreatment was highest in Nursing Homes (87 people), for Rule 42 (60), and for Rule 34 (61).

The overall disqualification rate, at 1.5% is fairly low. However, it is significant that between 1995 and 1998 more than 5,000 people applied to work in licensed facilities who were subsequently disqualified from such work. The data provided did not describe the average time it takes for a background study to be conducted and returned to the provider agency that submitted it. DHS reports that almost all of the background studies conducted during period investigated for this report were completed within the 15 day limit specified by statute. The main exceptions were late 1995 and early 1996 when all staff of MDH licensed facilities were required to have background studies completed, and between September 1997 and April 1998 when a staff vacancy in the unit could not be filled. Since the vacancy rate for staff providing direct contact services is as high as 24% for part-time positions in some types of provider agencies today, employers are under tremendous pressure to put new hires to

work long before a background study comes back clear. The statute requires only that the facility submit a background study form on a new hire before they begin providing direct contact services.

Questions for Future Studies. It was beyond the scope of this study to investigate background study results further. Future studies should examine the proportion of people who were disqualified had actually accepted the jobs they applied for, showed up for their first day and were working when the disqualification decision was returned. This information would be helpful in further assessing the value and effectiveness of the background study process.

Task 5: What are the set-aside rates for staff background studies conducted for provider agencies licensed under the following MN rules (5, 8,18, 34, 35,36, 38 42, 80, 203 203/42, and 223; and Nursing Homes) between 1995 and 1998?

The background study reports used for Task 4 were also used for Task 5. People who were disqualified due to their background study could work in a particular program under one of two circumstances. First, individuals who have had a background study returned saying they are disqualified for employment can request that their disqualification be set-aside to allow them to work that job. Second, a provider agency could request a variance for a person whose disqualification has not been set-aside to allow that person to work in a specific role despite their disqualification status.

*a. How many requests for reconsideration were received for each license type?*

Between 1995 and 1998, 332,863 background studies were conducted (See Table 5.1). Of those, 5,289 resulted in disqualification of an individual for a position. In all 1,543 requests were submitted by individuals asking that their disqualification be set-aside (29% of all disqualifications led to a request for reconsideration; See Figure 5.2). The proportion of disqualification reconsideration requests submitted varied from 21% for Boarding Care Homes and 24% for Rule 38 to 32% for Rule 35 and 31% for Nursing Homes. The proportion was between 25% and 29% for the remaining license types. The proportion of disqualifications submitted for reconsideration was 14% in 1995, 35% in 1996, 30% in 1997 and 27% in 1998 (See Figure 5.1).

In addition to individual requests for disqualifications to be set aside, there were a total of 135 requests by provider agencies to obtain a variance to employ someone with a disqualification. A total of 95% of requests for variances submitted by service providers between 1995 and 1998 in reviewed rule types were granted (with the largest number of these occurring in 1996). Many of these requests are renewals of the same variance as there are only 15 variances in effect statewide at this time. The high rate of variances granted was explained by the Licensing Division in that there is often preliminary discussions between providers and DHS regarding the likelihood that a variance request would be granted before a formal request is submitted.

*b. How many set-asides were done for each license type? What is the ratio of set-asides to requests for each license type?*

Figures 5.3 through 5.6 show the results of requests for reconsideration. Between 1995 and 1998, 1,287 reconsideration requests made by individuals were granted (an average of 322 per year). The total number of disqualifications set-aside in DHS programs ranged from three for Rule 223 (0.13% of all background studies for Rule 223) to 89 in Rule 34 (0.31%), and 94 in Rule 35 (1.17%; See Figure 5.5). The total number of set asides in MDH programs was 29 for Boarding Care Homes (0.36%), 601 for Nursing Homes (0.36%), and 322 for Licensed Home Care agencies (0.49%; See Figure 5.6). Overall, 83% of all reconsideration requests resulted in set-asides of disqualifications. People who requested reconsiderations were very successful in getting their disqualifications set-aside.

Another way to look at the set-asides is to see the proportion of all disqualifications that were ultimately set-aside. Between 1995 and 1998, 24% of all disqualifications were ultimately set-aside. However, only four disqualifications have actually been rescinded. In those cases, the information used to disqualify the person was incorrect. The proportion of disqualifications set-aside was 9% in 1995, 32% in 1996, 25% in 1997 and 20% in 1998. The proportion of disqualifications set-aside varied from 14% for Rule 203 to 28% for Nursing Homes. The

proportion of disqualifications set-aside was between 15% and 19% for Boarding Care Homes and Rules 34, 38 and 42. The proportion was between 20% and 24% for Rules 5, 18, 35, 36, 223, and Licensed Home Care Agencies.

**Questions for Future Studies.** The primary issue raised by this set of findings relates to the high proportion of disqualification reconsiderations that were ultimately set-aside. A sophisticated set of screening criteria are currently used to decide whether a disqualification can be set aside. The criteria consider the characteristic of the disqualifying event, the characteristics of the program where the person wants to work, and the characteristics of the person who was disqualified. As part of continuous quality improvement efforts, it may be helpful to periodically consider the following questions:

- Are there certain criteria for disqualification that are almost always set-aside?
- If so, could/should the law be changed so that certain minor or nonviolent offenses are eliminated as grounds for disqualification?
- Are there patterns emerging in which persons who have substantiated maltreatment findings have committed prior offenses that do not currently disqualify them for service?
- If so, could/should the law be changed to add certain offenses as grounds for disqualification?

*c. What is the rate of set-asides to background studies for each license type?*

Ultimately, 0.39% (or 3.9 per 1,000) of background studies were set-aside (See Table 5.1). The proportion of background studies that were ultimately set-aside was below 0.25% for Rules 5,18, 38, and 223, and above 0.35% for all three MDH programs and for Rule 36 (1.17%). While the differences (except for Rule 36) are small, there is a question of why Rule 36 licensed provider agencies are so much more likely to have set-asides than other types of provider agencies. Furthermore, the rate of set asides is more than five times higher for staff working in provider agencies licensed under Rule 35 compared with Rules 5,18,38 and 223, and two to three times higher than for other types of services.

Rules 34 and 35 provide interesting contrasts in the outcomes of background studies. These rules are very similar in the number of reconsiderations and set-asides processed. However, three times as many people from Rule 35 provider agencies were disqualified than from Rule 34 provider agencies. Twice as many people from Rule 35 provider agencies were disqualified for previous maltreatment than in Rule 34 provider agencies. However, more people in Rule 35 provider agencies sought reconsiderations, and more people had disqualifications set-aside. Finally, both rule types had one incident in the past 10 years of a person with a disqualification that had been set-aside subsequently engaging in substantiated maltreatment. The person from Rule 34 whose disqualification was set-aside had been initially disqualified for forgery, the person from Rule 35 for a drug conviction.

**Questions for Future Studies.** It was beyond the scope of this project to explore the reasons for differences in disqualification rates across license types. Further investigation should examine:

- To what extent are these differences explained by the fact that individuals applying for Rule 35 are more likely to appeal their disqualifications?
- To what extent is this due to preference in hiring practices being given to staff applying to work in Rule 35 programs who have themselves overcome the challenges of chemical dependence and concomitant social problems?
- To what extent is this due to providers who encourage such appeals, whether people applying for such jobs are more aware of their right to appeal, or whether they are less likely to leave/quit between the time the background study is submitted and the disposition is returned?

The implication for future practice depends in part on which of these or other explanations is most likely. If in fact different types of applicants have different levels of understanding about their right to appeal, it may be important to increase the information about the right to appeal given to some applicant types. This is especially true if applicants in one type of setting have less education or have disabilities that may interfere with their understanding of the right to appeal.

**Task 6: How many set-asides of background study disqualification were followed by subsequent substantiated maltreatment reports between 1995 and 1998?**

A very small number of people who have their disqualifications set-aside go on to engage in subsequent substantiated maltreatment. There were a total of 1,287 disqualifications set-aside between 1995 and 1998 (See Table 6.1). Two people who had their disqualifications set-aside between 1995 and 1998 subsequently engaged in substantiated maltreatment (a rate of 1.56 per 1,000 set asides). There were a total of 191 disqualifications set aside between 1991 and 1994. Three people who had disqualifications set-aside between 1991 and 1994 engaged in substantiated maltreatment after the set-aside (a rate of 15.6 per 1,000 set asides). The number of months between the set-aside and the subsequent maltreatment were 2,4,8,11 and 55. Four of the five incidents occurred within one year of the set-aside.

Prior to 1995 background studies were not required for people working in MDH facilities so the 1991 to 1994 figure is only for DHS licensed programs. This suggests that setting aside disqualifications in the manner in which it has been done between 1995 and 1998, carries relatively low levels of risk. To think about this in another way, of the 136 substantiated maltreatment or MOMA cases in DHS licensed facilities in 1998, 2 (1.5%) were committed by people who had disqualifications set-aside while 134 (98.5%) were by people who had not had a prior disqualification.

The rate at which people who had disqualifications set-aside subsequently engaged in substantiated maltreatment was 10 times lower in the years 1995 to 1998 (1.56 per 1,000) than in the years 1991 through 1994 (15.6 per 1,000). It was beyond the scope of this investigation to identify possible reasons for this dramatic drop, although with the changes in the background study rules at the end of 1995 and subsequent changes may have been a factor.

**Questions for Future Studies.** Future studies should consider the factors associated with this decline. Other questions that might merit further investigation would be:

- What are the characteristics of people who have been found to be involved in a substantiated maltreatment incident?
- How do characteristics of people involved in substantiated maltreatment differ from people who work in similar settings who have not been involved in such an incident?

**Table 6.1 MINNESOTA DEPARTMENT OF HUMAN SERVICES: Persons Disqualified, Set Aside, Maltreatment Occurred after Disqualification Set Aside**

| ualification Date/ on & Date of se | Facility Type, License N | Set Aside Date & Reason | Subsequent Maltreatment Date & Type | Facility Type, License N | Date Action Taken & Type |
|---|---|---|---|---|---|
| 24/92 - Original alification for 85 & 10/24/85 ry convictions ted 5/7/85 & 7/9/85 | DD Residential (Rule 34) | 4/28/92: 6+ years since arrests, 2.75 yrs service 1st study, recommendation from facility, clean record since offense, accepted responsibility, pd restitution | 11/16/96 Neglect when perpetrator told VA to go into deep end of pool after VA said couldn't swim. VA rescued & revived by others. | Same facility - DD Residential (Rule 34 ) | 8/15/97: Perpetrator left facility. Facility ordered to ensure that perpetrator not returned to direct contact position. Perpetrator didn't appeal maltreatment finding. |
| 20/94 - Original ualification for '92 theft & burglary iction (offense '82) & for 5/29/85 ıvated robbery iction (offense 3/84). study 7/8/94 | MI Residential for Children (Rule 8) Same type (Rules 5/36) | 7/7/94: 9+ & 12+ years since offenses, received treatment in prison, some insight & open about aggression, recommendations from instructor & facility. 8/2/94 based on 7/7/94 set aside | 11/11/94 & 11/12/94 (County Report) Sexual abuse when exposed self to 2 children 3 times, fondled 1 child, digitally penetrated 1 child | Same facility as 1st study - MI Residential for Children (Rule 8) | 12/22/94: Perpetrator disqualified and set asides rescinded. Facility ordered to immediately remove perpetrator from direct contact position. |
| 25/93 - Original disq. hysical abuse on '93 when used ssive force during aint resulting in neck e & cervical spine n. | MI Residential for Children (Rule 5) | 6/6/93: 10 yrs in field, identified what'd do differently, identified vulnerabilities of child, trained, accepted responsibility, good performance evaluation | 5/3/94: Physical abuse of child when used excessive force during restraint resulting in red mark on cheek, swelling above eye, bleeding elbow, burst blood vessels on neck & chin. | Same as 1st facility - MI Residential for Children (Rule 5) | 9/9/94: Perpetrator disqualified 10/6/94: Disqualification not set aside, immediate removal from direct contact ordered. 4/24/95: Disqualification not set aside |
| 19/98 - Original ualification for /95 felony drug iction (offense /95) | CD Residential (Rule 35) | 6/23/98: Discharged from probation, received treatment, recommendation from sponsor | 8/7/98-8/10/98: Neglect when perpetrator failed to supervise medication assistance to vulnerable adult | Same facility as 1st study - CD Residential (Rule 35) | 1/6/99: Perpetrator left facility. Facility ordered to ensure that perpetrator not returned to direct contact. |
| 0/5/99 - Original ualification for 2/91 5th degree estic assault (Offense /91) | DD - Day Training & Habilitation (Rule 38) | 11/2/98: Family counseling, 7 years in field with no problems, 3 letters of recommendation on outstanding performance from facility. | 7/8/99: Sexual contact over the clothing with a vulnerable adult. | Same facility as 1st study - DD DTH (Rule 38) | 7/8/99: Continuous supervision pending investigation. 7/15/99: Suspended without pay. 7/30/99: Terminated. 10/1/99: Investigation completed & facility ordered to ensure that perpetrator not returned to direct contact position. No appeal of maltreatment finding. |

**Task 7: For each task, describe the analyses conducted, problems and limitations of the data provided, and conclusions that can be drawn.**

The analyses conducted and problems or limitations of the data were discussed with the results for each task. Summary statements about changes across time and differences between rules are included in each section of this report.

**Task 8: For each task, provide recommendations about what needs to be done to test the validity and reliability of the maltreatment data currently collected by the STATE.**

In each section of this report, recommendations for future research are identified. Testing the validity and reliability of the maltreatment data currently collected by the STATE should begin by responding to those research questions. In addition to the recommendations reported throughout the report, we recommend several specific strategies to test validity and reliability of maltreatment data including:

- Conduct a series of focus groups, surveys or other information gathering interventions to gather information from county administrators, county case managers, families, consumers, provider administrators and staff and representatives from groups such as Legal Aid, the Ombudsman's Office, and various state agencies about what is working and what is not working in the current maltreatment reporting system and background study system. Review information gathered from some of these groups for the 2000 Minnesota Home and Community Based Waiver Evaluation project to identify areas requiring further exploration. Include in this study a series of in-depth interviews with individuals who process maltreatment reports (e.g., common entry point staff, DHS Licensing Division staff and administrators, data base administrators and analysis personnel) to identify what is working and what changes are needed. Use these sources to answer the research questions posed throughout this report and to verify, revise or discard recommendations made in this report.
- Conduct a systematic study that selects a small number of providers (who provide various types of services) to follow a sample of incidents as they go through the reporting system. For example, this study may follow the first 10 incident reports filed within each of a set of randomly selected agencies. The goal would be to learn how many and what types of reports get to various stages in the reporting process (e.g., incident report at the agency level, report to the common entry point, referral to DHS licensing, initial disposition by DHS, final disposition by DHS), and what happens to the reports along the way.
- Conduct a study to learn the final disposition of reports sent to DHS by the common entry point but referred to another entity by DHS.
- Conduct a content analysis of one year worth of substantiated reports and one year of reports that were screened out or referred to identify themes in the types of incidents reports and to identify possible training or technical assistance interventions needed.

**Task 9: To assist the STATE with future policy development, examine and describe what other, similar states are doing, and provide recommendations on what additional data collection and analyses are needed for the STATE have accurate and reliable reports on maltreatment and background studies.**

In Task 3 we summarized the policies and practices of 11 states regarding maltreatment report investigations and background studies. In this section we summarize some of the data collection and analysis strategies used in other states may be useful for Minnesota to provide accurate and reliable reports on maltreatment and background studies.

**Web Based Reporting Systems**

As access to the world wide web becomes pervasive, opportunities to use the web to streamline reporting and to enhance feedback are growing. Some states have now developed web based reporting systems in which all initial maltreatment reports to common entry points are submitted over the web. The advantage to a web based system for Minnesota would be that all reports, regardless of which agency was responsible for conducting the

investigation could be entered into a common database. This would enable the state as well as other entities (including counties and service providers) to produce reports summarizing the number of reports submitted, the number investigated and the final dispositions of those reports. This would also allow counties and state agencies to share information about maltreatment reports in real time.

Another innovative use of web based data bases was used in a couple of states that put their registries online. Individuals who had been convicted of crimes, had lost professional licenses (e.g., teachers, social workers, physicians, licensed practical nurses) or certifications (e.g., personal care attendants)were all entered into a single data base. Employers could use a password to access the data base to determine immediately whether an applicant was eligible for the posted job. The benefit of such a system would be that it could screen individuals across Health and Human Service roles for eligibility for employment quickly and easily. The drawback is the potential for privacy violations.

As an alternative to web based reporting, some states have established a single toll free phone number that people can call to report allegations of maltreatment. Such a system may be helpful in Minnesota if the number automatically routed each call to the nearest common entry point location. DHS reports that this idea was considered by the Vulnerable Adults Act task force in 1993 and 1994 but was rejected at that time.

**Audits Screening for Under-Reporting**

Some states reported that they conducted periodic validation studies to identify under-reporting or to identify policy relevant problems that require systemic intervention. For example, Illinois conducted annual under-reporting audits. Each year a different type of information was audited to determine if all known instances of maltreatment had been reported. Audits may focus on incident reports on file at provider locations, minutes of human rights committees that examined instances of aggression by consumers, or medication error reports to see if any incidents reported in those format that should have been investigated were not. The key component of this system that might be useful for Minnesota to consider is that these audits were not conducted by the licensing people. Instead they were conducted by quality enhancement staff. The goal of the audits was not to prompt licensing action. Instead the goal was to identify areas where technical assistance, training or policy changes could be used to improve outcomes.

**Studies of Specific Policy Issues/Trend Analyses**

New York also conducted periodic studies on a particular policy issue. For example, they published a report on whether interventions were needed to reduce suicides among persons in state operated facilities. Again, the goal was not to take particular licensing action, but rather to identify quality enhancement initiatives that could be instituted to improve outcomes.

Another strategy used by states we contacted was periodic analysis of trends in maltreatment reports to identify consistent or persistent problems. For example, one state noted that they were receiving a particularly high number of reports of bad outcomes related to choking on food or other items. Once they identified this theme they were able to design training to improve staff performance to reduce future choking incidents.

**Annual Reports to the Legislature and the Public**

Several states provided some form of annual report to the public and to the legislature on maltreatment investigations. For example, Illinois publishes an annual report summarizing the current rules regarding abuse, neglect and reportable incidents, the state's role, a summary of allegations and incidents for state operated services for persons with developmental disabilities or mental health needs, and describing other activities such as those by die quality care board, written responses, site visits and domestic abuse (Illinois Department of Human Services, 1999).

Michigan also produces an annual report on the status of recipient rights protection (Michigan Department of Community Health, 1998). Like the Illinois report, the Michigan report summarizes the number of complaints received, the number substantiated, and the number of reports that were considered abuse 1 or abuse II (but only for State Hospitals or centers, Private hospitals, and Community Mental Health Services programs. The

Michigan report is unique in that it summarizes all substantiated complaints by category and includes a brief case description, facility name and in some cases the remediation. One helpful characteristics of the Michigan report is its detailed list of the types of violations investigated (85+ categories are reported).

Ohio produces several reports annually. Among those reports are a one page fact sheet for the legislature describing the number and types of reports of "elder abuse, neglect and exploitation," and a graphical summary of the number of cases reported by counties to adult protective services broken down by type of report, age of referral, gender, race, marital status, living arrangement, and client mobility. While this report is not comprehensive, and does not breakdown substantiated versus unsubstantiated reports, it does provide an example of how demographic data may be used to inform policy makers regarding outcomes (e.g., of the 12,211 reports, only 977 were for people under 60 years old). More detailed analyses are available in Ohio from a statistical analysis package (probably SPSS or SAS). What is important to note is that the Ohio system includes, for at least some of its reports, information about the type of complaint, complaint source type (e.g., ombudsman staff, LTC provider/staff, anonymous), and determination.

In Pennsylvania, the Protection and Advocacy system provided a report on the individual advocacy cases it handled. The cases included both complaints of abuse or neglect as well as other advocacy needs. One component of the Pennsylvania report that Minnesota may wish to borrow is its inclusion of county population figures along with the number of cases coming from each county. Minnesota's 1998 statewide report of Vulnerable Adult maltreatment allegations provides a county breakdown of the number of complaints received but does not put that into context by reporting the county population or the number of service recipients in each county.

South Dakota produces an annual report of adult protective services maltreatment reports. Unlike Minnesota, the South Dakota system includes reports involving both family members and paid care providers. As a result it is able to list perpetrators by category (e.g., mother, father, son, daughter, other relative, non-relative, paid care giver, sibling, spouse, and self).

Of all the annual reports examined, the Texas report is most similar to Minnesota's. It breaks down allegations by program type and disposition. The one component it includes that the present study did not is the average days to complete an investigation (the average in FY 1999 was 11.2 days not including cases referred back to facilities and misclassified reports).

**Task 10: Recommend a process the STATE could use to further evaluate its data collection and analysis practices regarding maltreatment and background studies reporting.**

This section summarizes recommendations for identifying a process the state might use to further evaluate its data collection and analysis practices regarding maltreatment reporting, questionable death reporting, and background studies reporting.

**Stakeholder Involvement**

- Appoint an ongoing commission of stakeholders to discuss the current maltreatment and reporting procedures and to advise DHS Licensing Division staff on needed modifications to make the system more effective and accurate. This commission should involve family members, service recipients, advocacy groups, providers, professional organizations, child abuse/neglect experts, DHS staff, MDH staff, legal professionals and legislators. Commission members should be involved in identifying data elements examined in future studies and in receiving and using reports generated from that data.
- Conduct a process evaluation which includes qualitative in-depth interviews with provider agency staff, county personnel and multiple state level personnel regarding Minnesota's maltreatment reporting and investigation process.

**Data Systems and Reports**

- Prepare and disseminate comprehensive annual reports that describe initial and final dispositions for all allegations, along with the type of maltreatment alleged. These reports should analyze trends over the past 5 years. They should also include the number of maltreatment reports received, the initial disposition, the final disposition and the types of substantiated maltreatment per consumer in each license type.
- Future studies should use a complete set of data. Except for 1995, and for certain rules, this study did not review detailed reports on the types of maltreatment alleged or the dispositions for allegations of various types (e.g., physical abuse, sexual abuse, financial exploitation).
- Include information about the total number of people served by each type of licensed facility whenever maltreatment dispositions are reported so that the rate of maltreatment per consumer can be computed accurately.
- The DHS Licensing Information system should include basic classifications (e.g., physical abuse, sexual abuse, neglect, client to client harm, theft, unexplained injury) at all screening levels (common entry point at the counties, initial disposition by the state, final disposition and type of maltreatment). A centralized system that incorporates data from MDH, the Aging and Adult Services Division for VA and Family and Children's Services Division for MOMA reports would facilitate comprehensive reporting. This system should classify both consumer (age, gender, type of disability) and staff member (age, gender, prior investigations) demographics.
- Continue monitoring deaths among persons in licensed facilities. Annual reports on questionable deaths should include at least the total number of people who died while in the licensed setting, the number of deaths for which a maltreatment investigation was done, and the disposition of those investigations. Reports should include breakdowns by license type (clearly distinguishing adult foster care from adult foster care where waiver services are provided), type of disability, days to disposition, final disposition category, culpability, type of maltreatment alleged, age of person who died, and whether the death was preventable. Separate columns should be used on the report for each of these types of information.
- Monitor how long it takes to complete background studies, the cost and benefits of conducting background studies and potential risks related to provider agencies hiring individuals and having them start work only to later find out that the newly hired individual did not pass their background study.
- Develop a registry system for perpetrators of substantiated maltreatment. DHS reports that this is currently under development.

**Coordination Across Governmental Agencies**

- Develop a management information system that can be used by both counties and state agencies to collect, track and analyze data regarding maltreatment. Such a system is currently available for MOMA reports but does not include DHS, MDH and other state agency data. This system should allow for analysis of trends across counties as well as statewide. Having a central registry for providers listing negative licensing actions and substantiated maltreatment would assist counties in selecting providers with good track records throughout the state. DHS reports that work is now underway to accomplish this outcome.
- Investigate what happens to reports once they are referred to other agencies. Compare the differences and similarities between MDH and DHS investigations processes for maltreatment reports. Conduct a periodic examination of dispositions of county level child and adult protection investigations. The *Report of Vulnerable Adult Maltreatment Allegations: 1998 Statewide Results* noted that a report summarizing the results of investigations of maltreatment conducted by various lead agencies would be completed in 1999 but it was not available for this investigation.
- Investigate reporting and disposition practices at the provider and county level. Investigate whether provider agencies consistently report all relevant critical incidents to the common entry point. Investigate whether counties forward all reports involving potential maltreatment DHS Licensing Division. Review the comments made to researchers in the 2000 MN Home and Community Based Wavier Evaluation for issues to investigate.

Analyze and report on what actually happens to maltreatment reports that are assigned for investigation by the Investigations Unit. Analyze what happens to reports that don't meet the statutory definition of maltreatment but that involve critical incidents to identify trends in actions or inactions that should be addressed. Examine maltreatment allegations (e.g., allegations against family members living with the alleged victim; allegations regarding child foster care or family foster care; or allegations involving services not licensed by DHS or MDH) that are investigated at the county level rather than by the DHS Licensing Division. Identify common themes (e.g., consumer to consumer violence) and develop training, technical assistance or other quality enhancement techniques to address underlying problems.

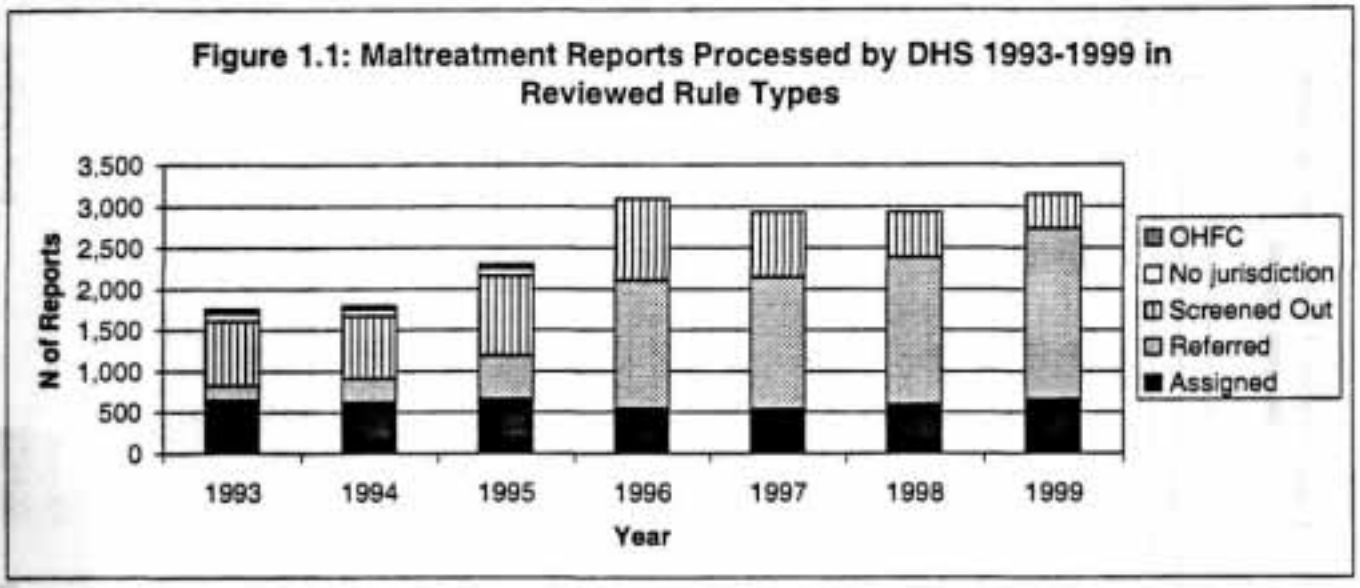
**Study the Impact of Policy Changes**

Examine how changes in rules and policies affect procedures and outcome data within DHS, MDH and counties. The past several years brought significant changes in legislation, policy and procedures (e.g., the 1995 revision to the Vulnerable Adults (VA) law, the 10/1/97 initiative to transfer background studies for adult foster care settings in 12 counties from the county to DHS; and annual revisions to the background studies provisions). While trend analyses conducted for this project revealed changes in reporting patterns or outcomes that were likely related to these statutory and procedural changes, further analysis is required to draw conclusions about the overall impact of those changes. It was beyond the scope of this study to interview agency staff in Minnesota with the exception of an interview with Jackie Spies and Jerry Kerber from the Licensing Division. Future evaluations should interview key individuals such as Investigations Unit staff, data collection systems staff, staff who analyze or prepare reports based on the data, and other stakeholders (e.g., Protection & Advocacy at the Disability Law Center, the Ombudsman for Mental Health and Mental Retardation, the Ombudsman for Long-Term Care, or the Department of Health).

Appendix

Table 1.1 Number of Maltreatment Reports Processed by DHS 1993 to 1999

| | 1993 | | 1994 | | 1995 | | 1996 | | 1997 | | 1998 | | 1999 | | 1993-1999 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Disposition | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % | Sum | % | Average |
| Received | 1,759 | | 1,795 | | 2,298 | | 3,092 | | 2,931 | | 2,937 | | 3,204 | | 18,016 | | 3,002.7 |
| Screened out | 782 | 44.5% | 754 | 42.0% | 972 | 42.3% | 995 | 32.2% | 791 | 27.0% | 550 | 18.7% | 422 | 13.2% | 5,266 | 29.2% | 877.7 |
| No jurisdiction | 106 | 6.0% | 89 | 5.0% | 91 | 4.0% | | | | | | | | | 286 | 1.6% | 47.7 |
| OHFC | 51 | 2.9% | 45 | 2.5% | 53 | 2.3% | | | | | | | | | 149 | 0.8% | 24.8 |
| Referred | 177 | 10.1% | 286 | 15.9% | 521 | 22.7% | 1,556 | 50.3% | 1,597 | 54.5% | 1,786 | 60.8% | 2,071 | 64.6% | 7,994 | 44.4% | 1,332.3 |
| Assigned | 641 | 36.4% | 621 | 34.6% | 661 | 28.8% | 541 | 17.5% | 537 | 18.3% | 591 | 20.1% | 651 | 20.3% | 4,243 | 23.6% | 707.2 |



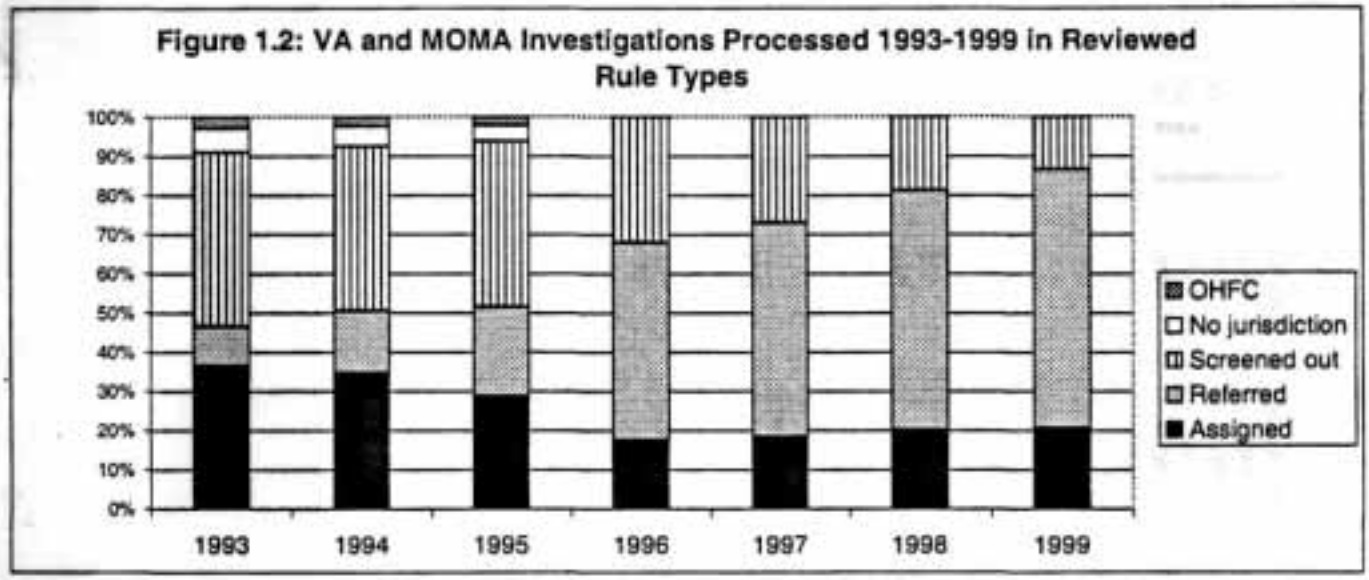



Table 1.2 Maltreatment Reports for Nursing Homes

Assignment of Cases

| FY | Reports | Assigned | Not Assigned | % Assigned |
|---|---|---|---|---|
| 95 | 452 | 307 | 145 | 68% |
| 96 | 573 | 410 | 163 | 72% |
| 97 | 405 | 291 | 114 | 72% |
| 98 | 389 | 296 | 93 | 76% |
| 99 | 463 | 334 | 129 | 72% |
| Total | 2282 | 1638 | 644 | 72% |

Disposition of Maltreatment Cases

| FY | Substantiated | Inconclusive | Unsubstantiated | Total Completed |
|---|---|---|---|---|
| 95 | 38 | 34 | 22 | 94 |
| 96 | 4 | 11 | 14 | 29 |
| 97 | 35 | 71 | 19 | 125 |
| 98 | 72 | 159 | 43 | 274 |
| 99 | 83 | 141 | 52 | 276 |
| Total | 232 | 416 | 150 | 798 |

Percent of Completed Cases

| FY | Substantiated | Inconclusive | Unsubstantiated | Total |
|---|---|---|---|---|
| 95 | 40% | 36% | 23% | 100% |
| 96 | 14% | 38% | 48% | 100% |
| 97 | 28% | 57% | 15% | 100% |
| 98 | 26% | 58% | 16% | 100% |
| 99 | 30% | 51% | 19% | 100% |
| Total | 29% | 52% | 19% | 100% |

**Figure 1.3 Assignment of Maltreatment Reports for Nursing Homes**

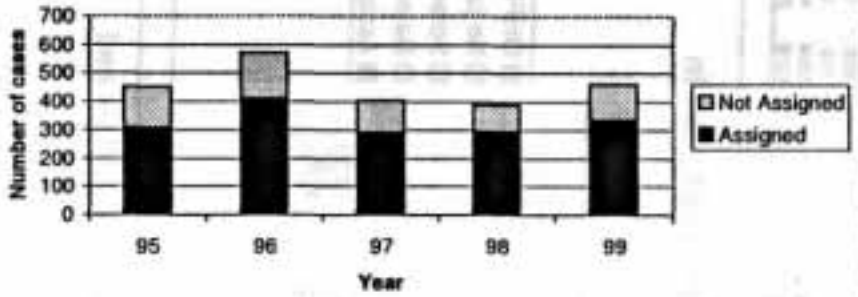



**Figure 1.4 Disposition of Maltreatment Cases in Nursing Homes 1995-1999**

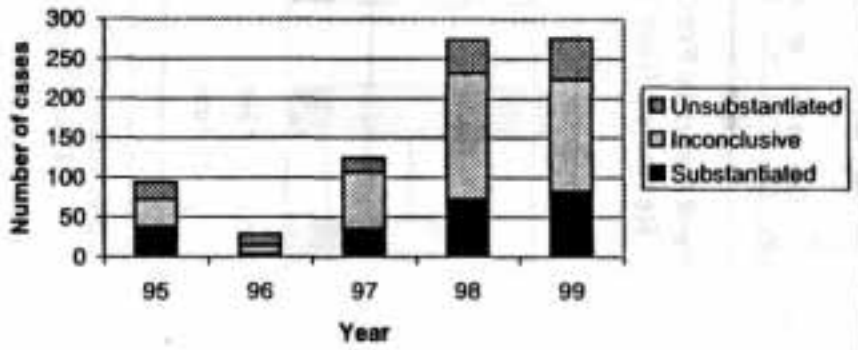


Table 1.3 Number of MCMA or VA Reports by Rule for 1996 - 1998

| Rule | 1996 | | 1997 | | 1998 | | Total | | N Consumers | | | Rate per Consumer | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | N | % | 1996 | 1997 | 1998 | 1996 | 1997 | 1998 |
| Children | | | | | | | | | | | | | | |
| 5 | N | % | N | % | N | % | | | | | | | | |
| Received | 98 | | 114 | | 118 | | 330 | | | | | | | |
| Screened out | 28 | 28.6% | 27 | 23.7% | 12 | 10.2% | 67 | 20.3% | | | | | | |
| Referred | 41 | 41.8% | 54 | 47.4% | 81 | 68.6% | 176 | 53.3% | | | | | | |
| Assigned | 29 | 29.6% | 33 | 28.9% | 25 | 21.2% | 87 | 26.4% | | | | | | |
| 8 | N | % | N | % | N | % | | | | | | | | |
| Received | 22 | | 27 | | 34 | | 83 | | | | | | | |
| Screened out | 7 | 31.8% | 7 | 25.9% | 1 | 2.9% | 15 | 18.1% | | | | | | |
| Referred | 5 | 22.7% | 16 | 59.3% | 19 | 55.9% | 40 | 48.2% | | | | | | |
| Assigned | 10 | 45.5% | 4 | 14.8% | 14 | 41.2% | 28 | 33.7% | | | | | | |
| MR/DD | | | | | | | | | | | | | | |
| 18 | N | % | N | % | N | % | | | | | | | | |
| Received | 40 | | 31 | | 17 | | 91 | | 1278 | 1278 | 1484 | 0.034 | 0.024 | 0.011 |
| Screened out | 25 | 58.1% | 17 | 54.8% | 6 | 35.3% | 48 | 52.7% | 1278 | 1278 | 1484 | 0.020 | 0.013 | 0.004 |
| Referred | 14 | 32.6% | 10 | 32.3% | 8 | 47.1% | 32 | 35.2% | 1278 | 1278 | 1484 | 0.011 | 0.008 | 0.005 |
| Assigned | 4 | 9.3% | 4 | 12.9% | 3 | 17.6% | 11 | 12.1% | 1278 | 1278 | 1484 | 0.003 | 0.003 | 0.002 |
| 34 | N | % | N | % | N | % | | | | | | | | |
| Received | 667 | | 511 | | 467 | | 1,645 | | 3826 | 3804 | 3804 | 0.174 | 0.142 | 0.123 |
| Screened out | 436 | 65.4% | 361 | 70.6% | 304 | 65.1% | 1,101 | 66.9% | 3826 | 3804 | 3804 | 0.114 | 0.100 | 0.080 |
| Referred | 126 | 18.9% | 51 | 10.0% | 84 | 18.0% | 261 | 15.9% | 3826 | 3804 | 3804 | 0.033 | 0.014 | 0.022 |
| Assigned | 105 | 15.7% | 99 | 19.4% | 79 | 16.9% | 283 | 17.2% | 3826 | 3804 | 3804 | 0.027 | 0.027 | 0.021 |
| 38 | N | % | N | % | N | % | | | | | | | | |
| Received | 344 | | 322 | | 305 | | 971 | | 9787 | 10216 | 10447 | 0.035 | 0.032 | 0.029 |
| Screened out | 236 | 68.6% | 180 | 55.9% | 123 | 40.3% | 539 | 55.5% | 9787 | 10216 | 10447 | 0.024 | 0.018 | 0.012 |
| Referred | 68 | 19.8% | 102 | 31.7% | 133 | 43.6% | 303 | 31.2% | 9787 | 10216 | 10447 | 0.007 | 0.010 | 0.013 |
| Assigned | 40 | 11.6% | 40 | 12.4% | 49 | 16.1% | 129 | 13.3% | 9787 | 10216 | 10447 | 0.004 | 0.004 | 0.005 |
| 42 | N | % | N | % | N | % | | | | | | | | |
| Received | 87 | | 89 | | 58 | | 234 | | 1316 | 1320 | 1321 | 0.051 | 0.075 | 0.051 |
| Screened out | 32 | 47.8% | 56 | 56.6% | 19 | 27.9% | 107 | 45.7% | 1316 | 1320 | 1321 | 0.024 | 0.042 | 0.014 |
| Referred | 21 | 31.3% | 28 | 28.3% | 34 | 50.0% | 83 | 35.5% | 1316 | 1320 | 1321 | 0.016 | 0.021 | 0.026 |
| Assigned | 14 | 20.9% | 17 | 17.2% | 15 | 22.1% | 46 | 19.7% | 1316 | 1320 | 1321 | 0.011 | 0.013 | 0.011 |
| 203/42 | N | % | N | % | N | % | | | | | | | | |
| Received | | | | | 508 | | 508 | | | | 5190 | | | 0.098 |
| Screened out | | | | | 3 | 0.6% | 3 | 0.6% | | | 5190 | | | 0.001 |
| Referred | | | | | 426 | 83.9% | 426 | 83.9% | | | 5190 | | | 0.082 |
| Assigned | | | | | 79 | 15.6% | 79 | 15.6% | | | 5190 | | | 0.015 |
| Adult Other | | | | | | | | | | | | | | |
| 35 | N | % | N | % | N | % | | | | | | | | |
| Received | 78 | | 85 | | 87 | | 250 | | | | 1832 | | | 0.047 |
| Screened out | 33 | 42.3% | 24 | 28.2% | 12 | 13.8% | 69 | 27.6% | | | 1832 | | | 0.007 |
| Referred | 27 | 34.6% | 41 | 48.2% | 52 | 59.8% | 120 | 48.0% | | | 1832 | | | 0.028 |
| Assigned | 18 | 23.1% | 20 | 23.5% | 23 | 26.4% | 61 | 24.4% | | | 1832 | | | 0.013 |
| 36 | N | % | N | % | N | % | | | | | | | | |
| Received | 239 | | 132 | | 133 | | 504 | | | | 1040 | | | 0.128 |
| Screened out | 149 | 62.3% | 55 | 41.7% | 39 | 29.3% | 243 | 48.2% | | | 1040 | | | 0.038 |
| Referred | 65 | 27.2% | 68 | 51.5% | 83 | 62.4% | 216 | 42.9% | | | 1040 | | | 0.080 |
| Assigned | 25 | 10.5% | 9 | 6.8% | 11 | 8.3% | 45 | 8.9% | | | 1040 | | | 0.011 |
| 60 | N | % | N | % | N | % | | | | | | | | |
| Received | 0 | | 2 | | 1 | | 3 | | | | | | | |
| Screened out | 0 | 0.0% | 1 | 50.0% | 1 | 100.0% | 2 | 66.7% | | | | | | |
| Referred | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | | | | | | |
| Assigned | 0 | 0.0% | 1 | 50.0% | 0 | 0.0% | 1 | 33.3% | | | | | | |
| 203 | N | % | N | % | N | % | | | | | | | | |
| Received | 1,091 | | 1,091 | | 710 | | 2,892 | | | | 4787 | | | 0.148 |
| Screened out | 2 | 0.2% | 17 | 1.6% | 17 | 2.4% | 36 | 1.2% | | | 4787 | | | 0.004 |
| Referred | 865 | 79.3% | 835 | 76.5% | 481 | 67.7% | 2,181 | 75.4% | | | 4787 | | | 0.100 |
| Assigned | 224 | 20.5% | 239 | 21.9% | 212 | 29.9% | 675 | 23.3% | | | 4787 | | | 0.044 |
| 223 | N | % | N | % | N | % | | | | | | | | |
| Received | 6 | | 5 | | 11 | | 22 | | | | | | | |
| Screened out | 4 | 66.7% | 3 | 60.0% | 1 | 9.1% | 8 | 36.4% | | | | | | |
| Referred | 2 | 33.3% | 1 | 20.0% | 7 | 63.6% | 10 | 45.5% | | | | | | |
| Assigned | 0 | 0.0% | 1 | 20.0% | 3 | 27.3% | 4 | 18.2% | | | | | | |
| Total DHS (Reviewed Rules) | | | | | | | 7,534 | | | | | | | |

Note: Before 1998, distinctions between Rule 203 and 203/42 were not clearly maintained, so for this table and associated figures those groups are not separated until 1998

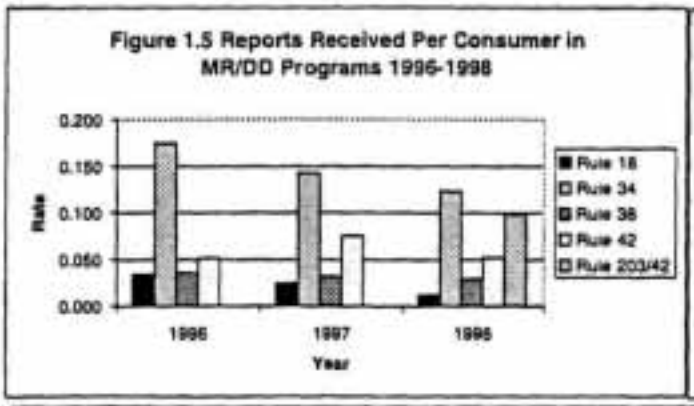


Figure 1.5 Reports Received Per Consumer in MR/DD Programs 1996-1998
Rate
0.200
0.150
0.100
0.050
0.000
1996
1997
1998
Year
Rule 18
Rule 34
Rule 38
Rule 42
Rule 203/42

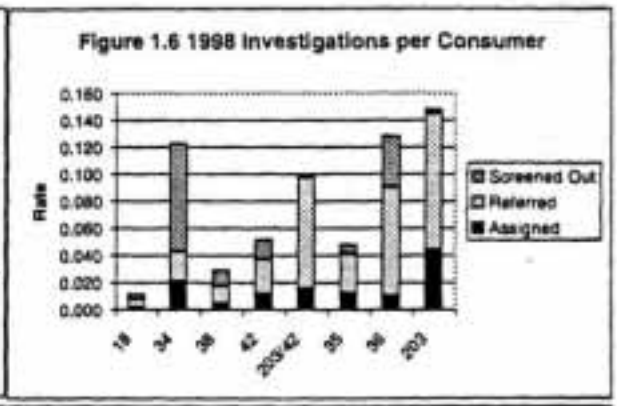


Figure 1.6 1998 Investigations per Consumer
Rate
0.160
0.140
0.120
0.100
0.080
0.060
0.040
0.020
0.000
Screened Out
Referred
Assigned

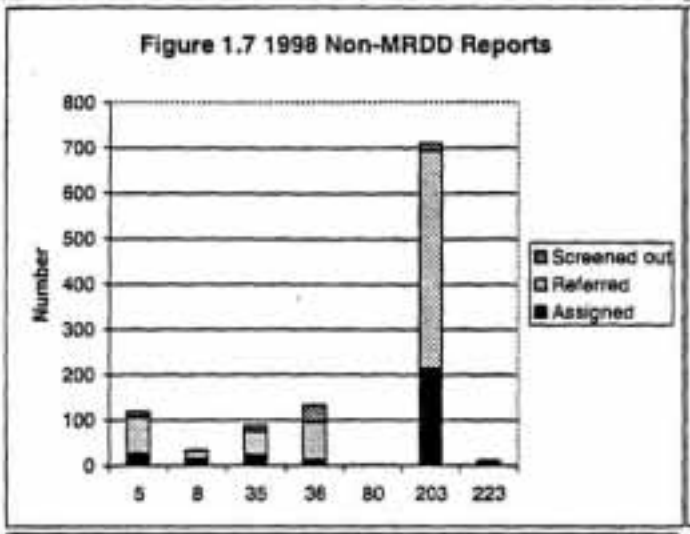


Figure 1.7 1998 Non-MRDD Reports
Number
800
700
600
500
400
300
200
100
0
5
8
35
36
80
203
223
Screened out
Referred
Assigned

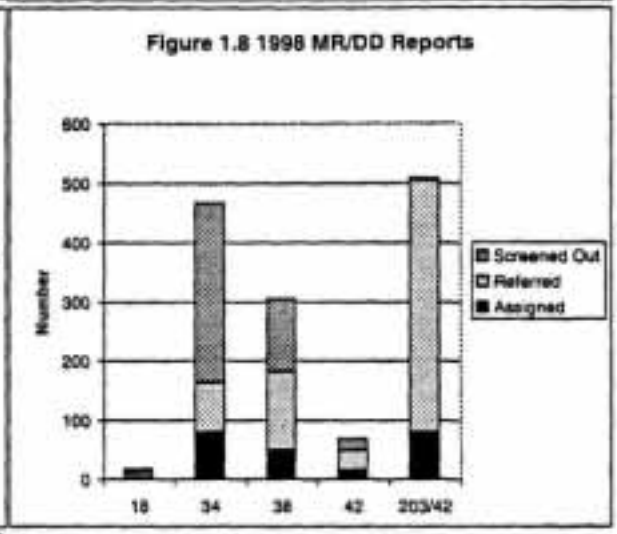


Figure 1.8 1998 MR/DD Reports
Number
600
500
400
300
200
100
0
18
34
38
42
203/42
Screened Out
Referred
Assigned

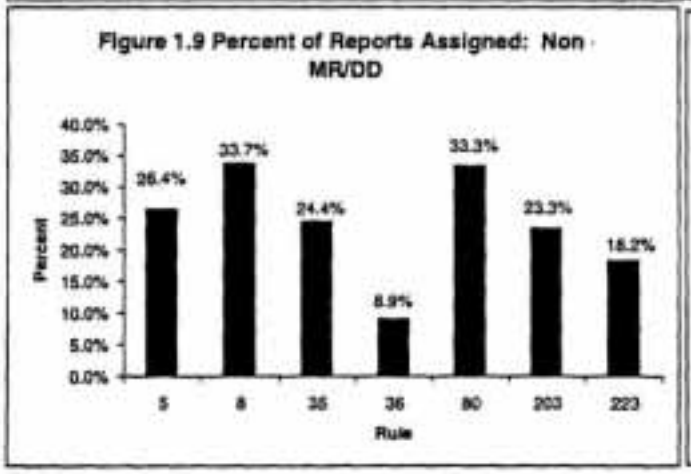


Figure 1.9 Percent of Reports Assigned: Non-MR/DD
Percent
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
26.4%
33.7%
24.4%
8.9%
33.3%
23.3%
18.2%
5
8
35
36
80
203
223
Rule

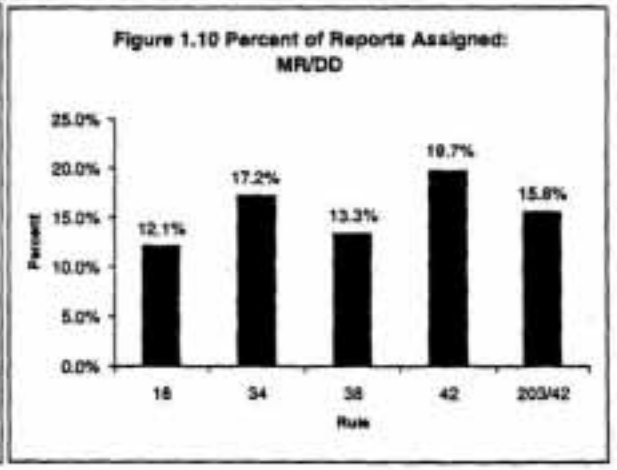


Figure 1.10 Percent of Reports Assigned: MR/DD
Percent
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
12.1%
17.2%
13.3%
19.7%
15.8%
18
34
38
42
203/42
Rule

Table 1.4 Maltreatment of Minors Determinations 1995 - 1998

**Rule 5**

| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | 7 | 34 | 41 | 17.1% | 82.9% | 100.0% |
| 1996 | 2 | 20 | 22 | 9.1% | 90.9% | 90.9% |
| 1997 | 3 | 25 | 28 | 10.7% | 89.3% | 89.3% |
| 1998 | 5 | 26 | 31 | 16.1% | 83.9% | 83.9% |
| Total | 17 | 105 | 122 | 13.9% | 86.1% | 86.1% |

**Rule 8**

| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | 3 | 27 | 30 | 10.0% | 90.0% | 100.0% |
| 1996 | 4 | 7 | 11 | 36.4% | 63.6% | 100.0% |
| 1997 | 2 | 4 | 6 | 33.3% | 66.7% | 100.0% |
| 1998 | 2 | 11 | 13 | 15.4% | 84.6% | 100.0% |
| Total | 11 | 49 | 60 | 18.3% | 81.7% | 81.7% |

**Rule 18**

| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 1996 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 1997 | 1 | 0 | 1 | 100.0% | 0.0% | 100.0% |
| 1998 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| Total | 1 | 0 | 1 | 100.0% | 0.0% | 0.0% |

**Rule 34**

| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | | | | | | |
| 1996 | 0 | 4 | 4 | 0.0% | 100.0% | 100.0% |
| 1997 | 3 | 6 | 9 | 33.3% | 66.7% | 100.0% |
| 1998 | 5 | 8 | 13 | 38.5% | 61.5% | 100.0% |
| Total | 8 | 18 | 26 | 30.8% | 69.2% | 69.2% |

**Rule 35**

| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | 0 | 1 | 1 | 0.0% | 100.0% | 100.0% |
| 1996 | 0 | 1 | 1 | 0.0% | 100.0% | 100.0% |
| 1997 | 5 | 0 | 5 | 100.0% | 0.0% | 100.0% |
| 1998 | 0 | 2 | 2 | 0.0% | 100.0% | 100.0% |
| Total | 5 | 4 | 9 | 55.6% | 44.4% | 44.4% |

**Rule 36**

| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | 0 | 1 | 1 | 0.0% | 100.0% | 100.0% |
| 1996 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 1997 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 1998 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| Total | 0 | 1 | 1 | 0.0% | 100.0% | 100.0% |

**Rule 42**

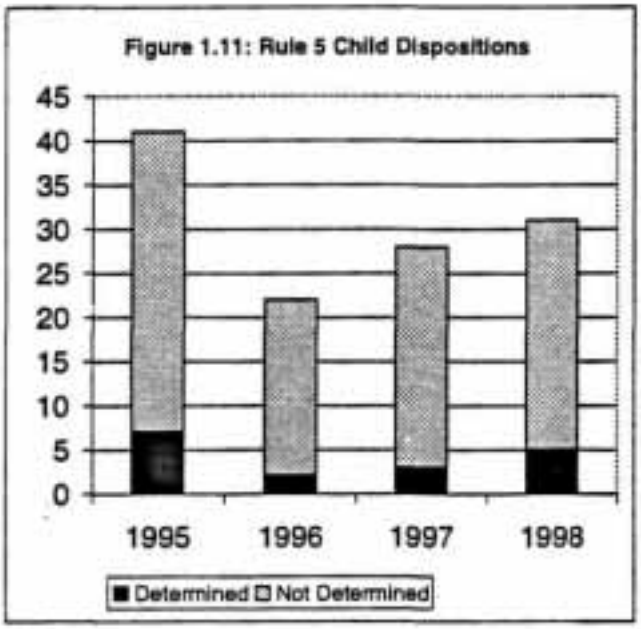
| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | | | | | | |
| 1996 | 0 | 2 | 2 | 0.0% | 100.0% | 100.0% |
| 1997 | 0 | 3 | 3 | 0.0% | 100.0% | 100.0% |
| 1998 | 0 | 1 | 1 | 0.0% | 100.0% | 100.0% |
| Total | 0 | 6 | 6 | 0.0% | 100.0% | 100.0% |

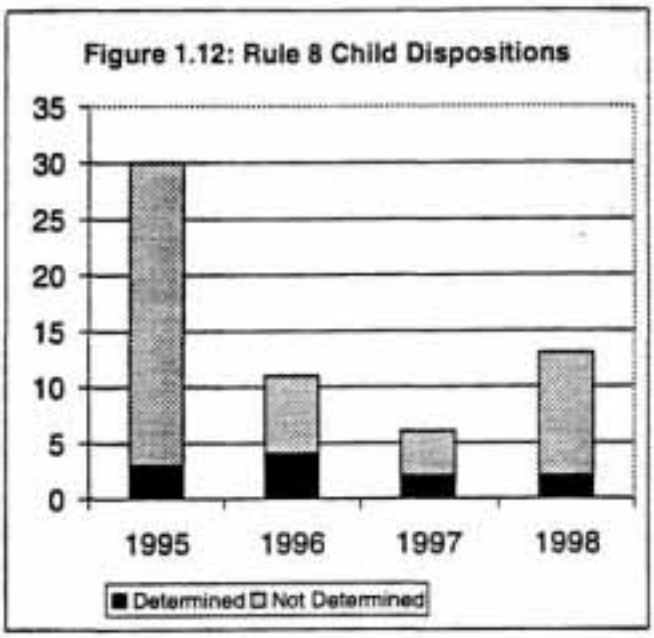
**Rule 203/42**

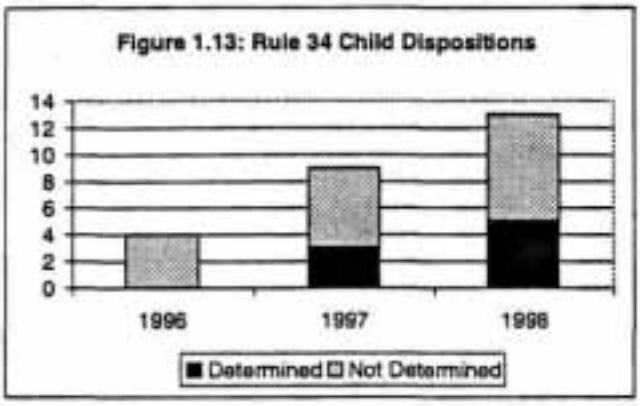
| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | | | | | | |
| 1996 | 0 | 2 | 2 | 0.0% | 100.0% | 100.0% |
| 1997 | 1 | 0 | 1 | 100.0% | 0.0% | 100.0% |
| 1998 | 0 | 1 | 1 | 0.0% | 100.0% | 100.0% |
| Total | 1 | 3 | 4 | 25.0% | 75.0% | 75.0% |

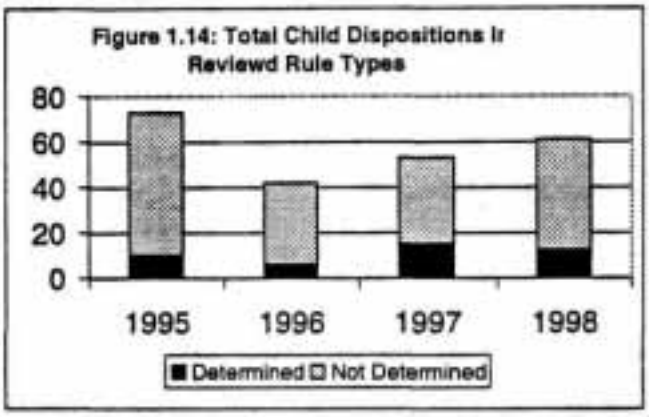
**Total (Reviewed Rules)**

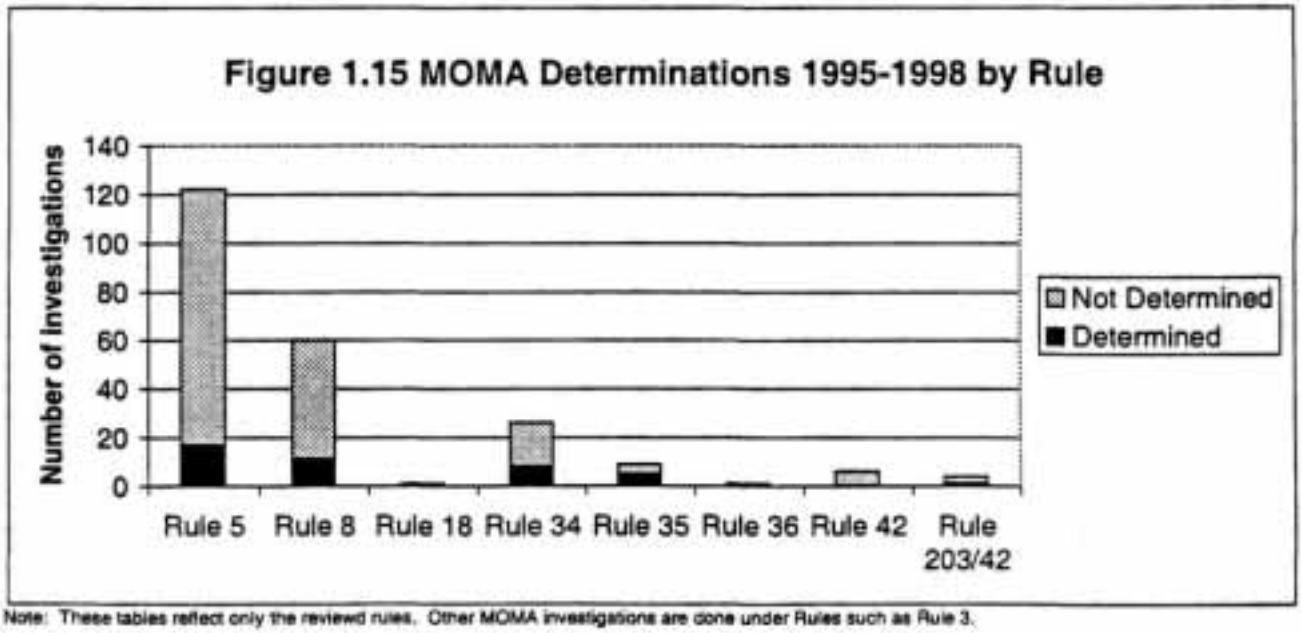
| Year | (MOMA) Determined | (MOMA) Not Determined | Total | (MOMA) Determined | (MOMA) Not Det. | Total |
|---|---|---|---|---|---|---|
| 1995 | 10 | 63 | 73 | 13.7% | 86.3% | 100.0% |
| 1996 | 6 | 36 | 42 | 14.3% | 85.7% | 100.0% |
| 1997 | 15 | 38 | 53 | 28.3% | 71.7% | 100.0% |
| 1998 | 12 | 49 | 61 | 19.7% | 80.3% | 100.0% |
| Total | 43 | 186 | 229 | 18.8% | 81.2% | 81.2% |




Note: These tables reflect only the reviewd rules. Other MOMA investigations are done under Rules such as Rule 3.

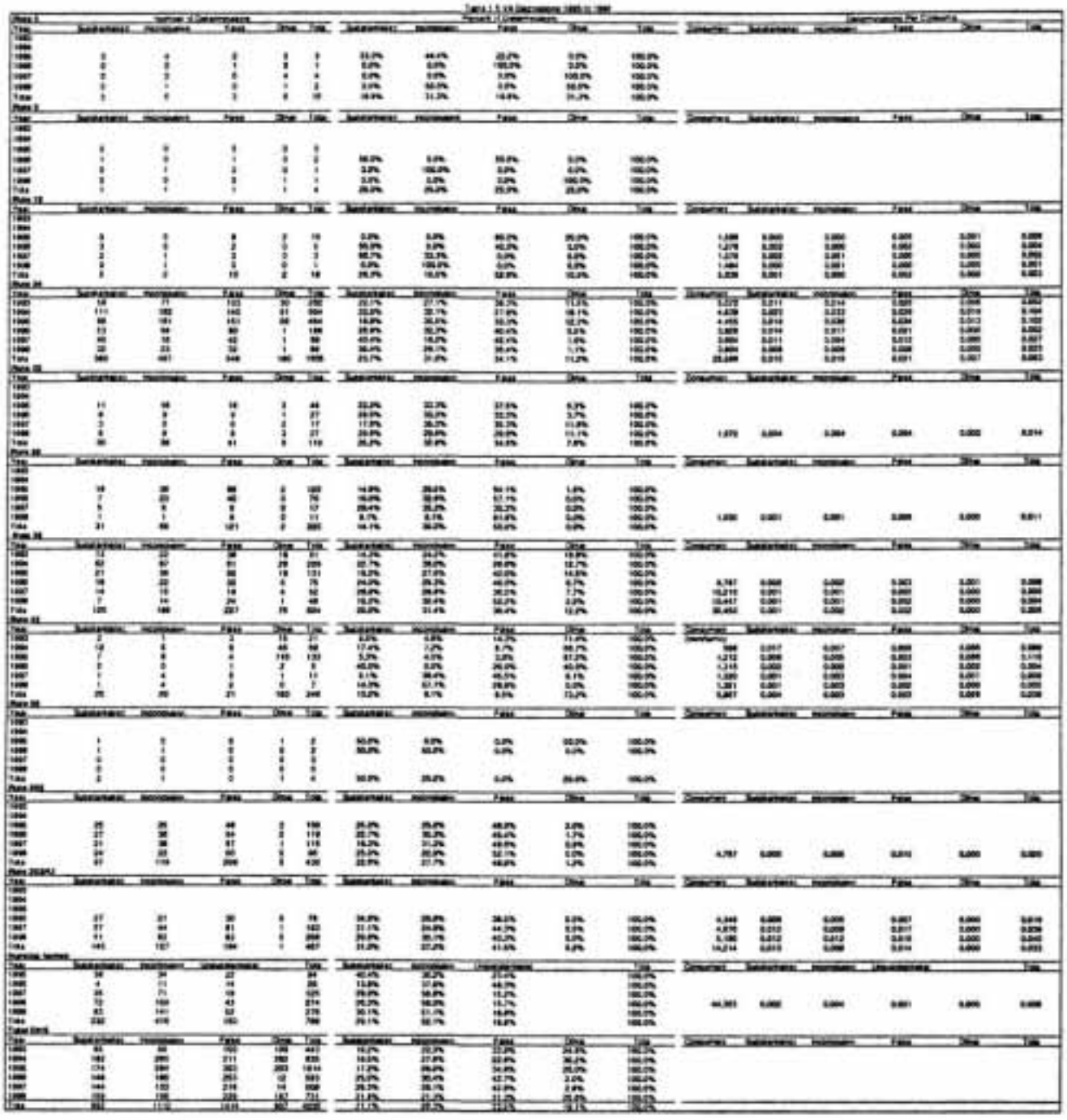


Figure 1.16 Total Nursing Home VA Dispositions 1996-1999

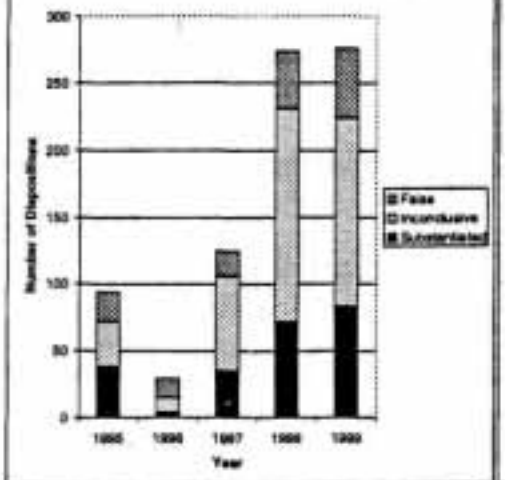



Figure 1.17: Total DHS VA Dispositions in Reviewed Rule Types

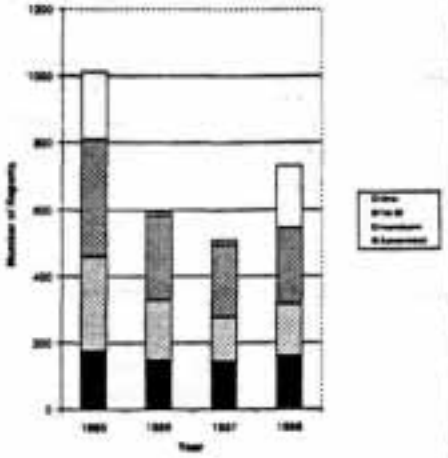


Figure 1.18 Percent of VA Investigations Substantiated 1996-1999

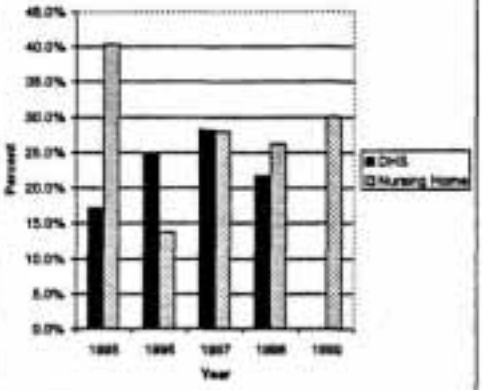



Figure 1.19 Average Rate of VA Reports Investigated per Consumer

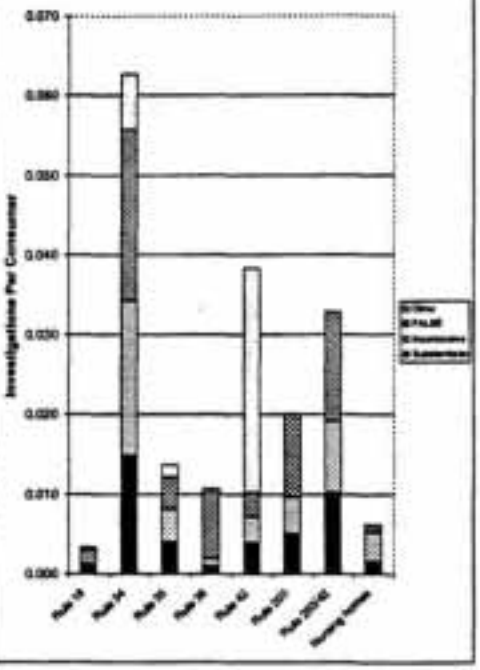



Figure 1.20 Rule 38 VA Reports Investigated per Consumer 1996-1998 in Reviewed Rule Types

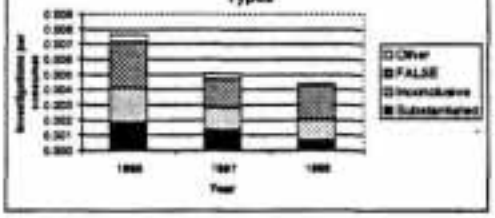


Figure 1.21: Rule 18 Adult Dispositions

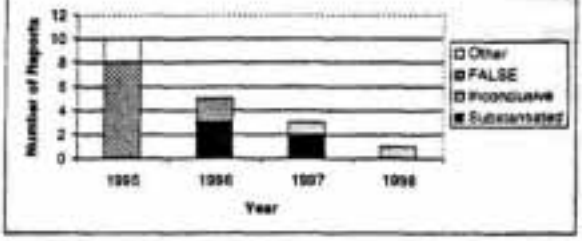



Figure 1.22: Rule 34 Adult Dispositions

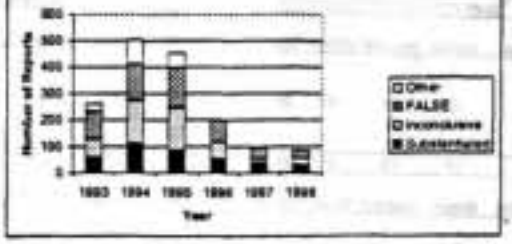



Figure 1.23: Rule 38 Adult Dispositions

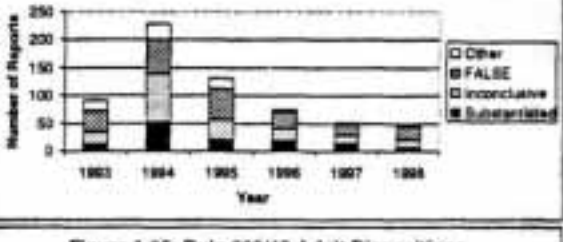



Figure 1.24: Rule 42 Adult Dispositions

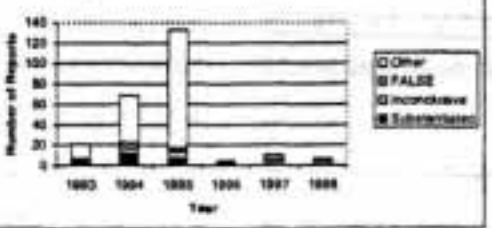



Figure 1.25: Rule 203/42 Adult Dispositions

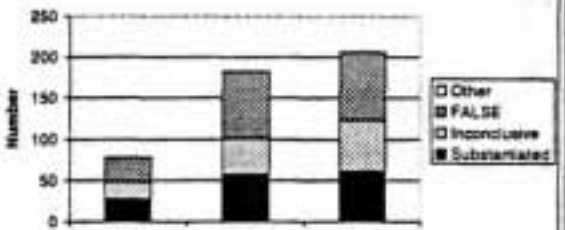



Figure 1.26: Rule 203 Adult Dispositions

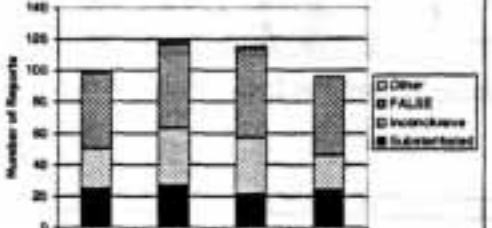



Figure 1.27: Rule 35 Adult Dispositions

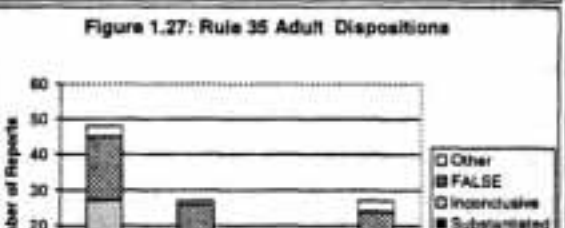
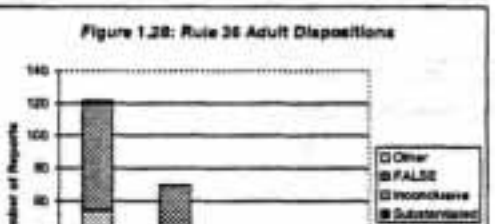



Figure 1.28: Rule 36 Adult Dispositions



| Table 1.6 Types of Abuse for Substantiated Maltreatment in DHS Facilities 1993-1997 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Rule 5** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 1995 | 5 | 13 | 16 | 0 | 34 | 14.7% | 38.2% | 47.1% | 0.0% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 5 | 13 | 16 | 0 | 34 | 14.7% | 38.2% | 47.1% | 0.0% | 100.0% |
| **Rule 8** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 1995 | 7 | 5 | 9 | 0 | 21 | 33.3% | 23.8% | 42.9% | 0.0% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 7 | 5 | 9 | 0 | 21 | 33.3% | 23.8% | 42.9% | 0.0% | 100.0% |
| **Rule 18** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 1995 | 0 | 0 | 7 | 3 | 10 | 0.0% | 0.0% | 70.0% | 30.0% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 0 | 0 | 7 | 3 | 10 | 0.0% | 0.0% | 70.0% | 30.0% | 100.0% |
| **Rule 34** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | 9 | 4 | 28 | 19 | 58 | 15.5% | 6.9% | 44.8% | 32.8% | 100.0% |
| 1994 | 16 | 3 | 55 | 37 | 111 | 14.4% | 2.7% | 49.5% | 33.3% | 100.0% |
| 1995 | 17 | 2 | 45 | 22 | 86 | 19.8% | 2.3% | 52.3% | 25.6% | 100.0% |
| 1996 | 11 | 2 | 25 | 20 | 58 | 19.0% | 3.4% | 43.1% | 34.5% | 100.0% |
| 1997 | 6 | 0 | 12 | 12 | 30 | 20.0% | 0.0% | 40.0% | 40.0% | 100.0% |
| Total | 59 | 11 | 163 | 110 | 343 | 17.2% | 3.2% | 47.5% | 32.1% | 100.0% |
| **Rule 35** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 1995 | 11 | 1 | 19 | 5 | 36 | 30.6% | 2.8% | 52.8% | 13.9% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 11 | 1 | 19 | 5 | 36 | 30.6% | 2.8% | 52.8% | 13.9% | 100.0% |
| **Rule 36** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 1995 | 14 | 14 | 72 | 30 | 130 | 10.8% | 10.8% | 55.4% | 23.1% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 14 | 14 | 72 | 30 | 130 | 10.8% | 10.8% | 55.4% | 23.1% | 100.0% |
| **Rule 38** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | 4 | 2 | 5 | 2 | 13 | 30.8% | 15.4% | 38.5% | 15.4% | 100.0% |
| 1994 | 8 | 2 | 30 | 14 | 52 | 11.5% | 3.8% | 57.7% | 26.9% | 100.0% |
| 1995 | 0 | 0 | 15 | 6 | 21 | 0.0% | 0.0% | 71.4% | 28.6% | 100.0% |
| 1996 | 2 | 1 | 14 | 1 | 18 | 11.1% | 5.6% | 77.8% | 5.6% | 100.0% |
| 1997 | 4 | 0 | 7 | 2 | 13 | 30.8% | 0.0% | 53.8% | 15.4% | 100.0% |
| Total | 18 | 5 | 71 | 25 | 117 | 13.7% | 4.3% | 60.7% | 21.4% | 100.0% |
| **Rule 42** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | 0 | 1 | 1 | 0 | 2 | 0.0% | 50.0% | 50.0% | 0.0% | 100.0% |
| 1994 | 1 | 0 | 5 | 6 | 12 | 8.3% | 0.0% | 41.7% | 50.0% | 100.0% |
| 1995 | 0 | 1 | 3 | 3 | 7 | 0.0% | 14.3% | 42.9% | 42.9% | 100.0% |
| 1996 | 0 | 0 | 1 | 1 | 2 | 0.0% | 0.0% | 50.0% | 50.0% | 100.0% |
| 1997 | 0 | 1 | 2 | 0 | 3 | 0.0% | 33.3% | 66.7% | 0.0% | 100.0% |
| Total | 1 | 3 | 12 | 10 | 26 | 3.8% | 11.5% | 46.2% | 38.5% | 100.0% |
| **Rule 60** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 1995 | 0 | 2 | 0 | 0 | 2 | 0.0% | 100.0% | 0.0% | 0.0% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 0 | 2 | 0 | 0 | 2 | 0.0% | 100.0% | 0.0% | 0.0% | 100.0% |
| **Rule 233** | | | | | | | | | | |
| Year | Physical | Sexual | Neglect | Other | Total | Physical | Sexual | Neglect | Other | Total |
| 1993 | | | | | | | | | | |
| 1994 | | | | | | | | | | |
| 10/95-12/95 | 8 | 0 | 33 | 17 | 58 | 13.8% | 0.0% | 56.9% | 29.3% | 100.0% |
| 1996 | | | | | | | | | | |
| 1997 | | | | | | | | | | |
| Total | 8 | 0 | 33 | 17 | 58 | 13.8% | 0.0% | 56.9% | 29.3% | 100.0% |
| Grand Total | 121 | 54 | 402 | 200 | 777 | 15.6% | 6.9% | 51.7% | 25.7% | 100.0% |

Figure 1.29: Rule 34 Types of Substantiated Maltreatment

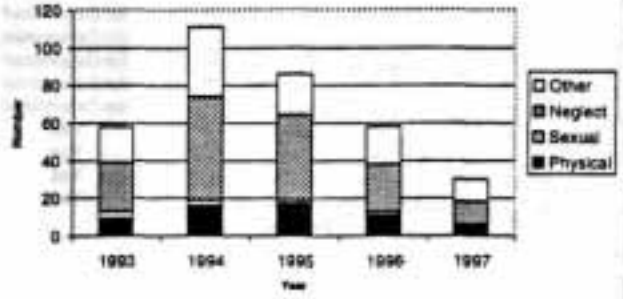



Figure 1.30: Rule 38 Types of Substantiated Maltreatment

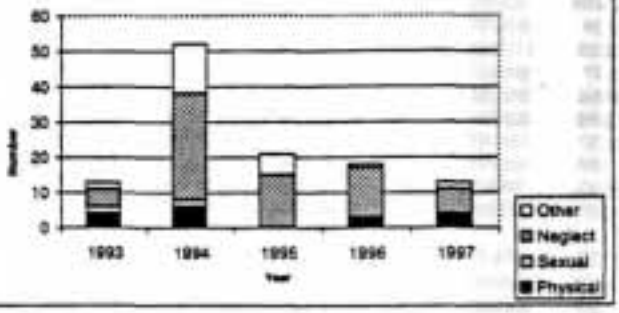



Figure 1.31: Rule 42 Types of Abuse

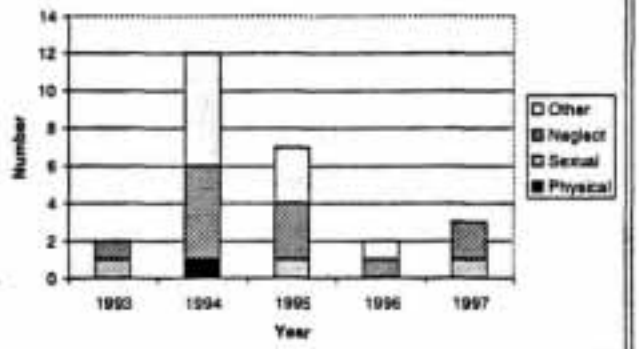



Figure 1.32: Type of Substantiated Abuse in 1995

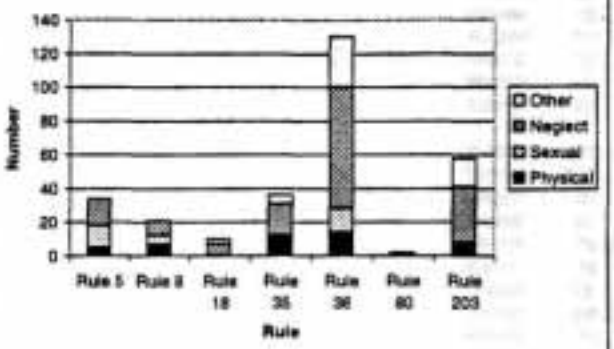



Figure 1.33 Overall Proportion of Substantiated Abuse of Each Type in Reviewed Rule Types

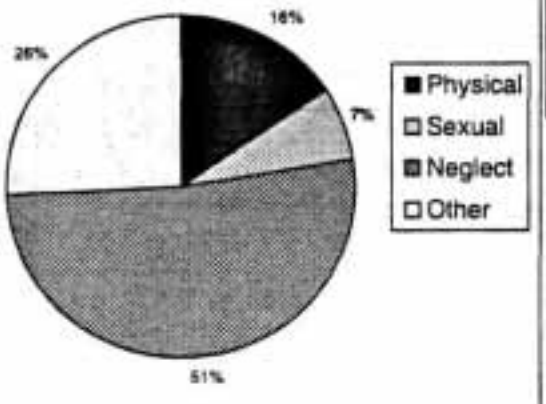



Figure 1.34 Proportion of Abuse in Various Categories - Part 1

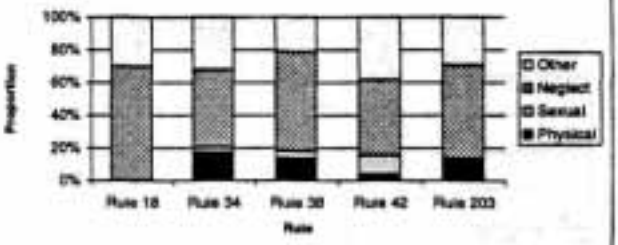
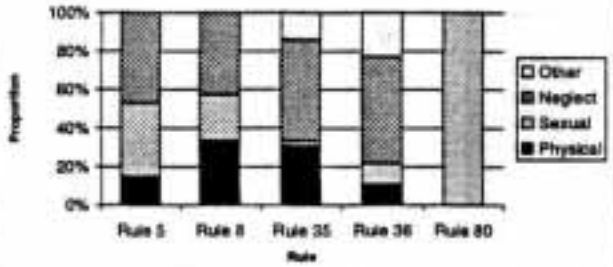



Figure 1.35 Proportion of Abuse in Various Categories - Part 2

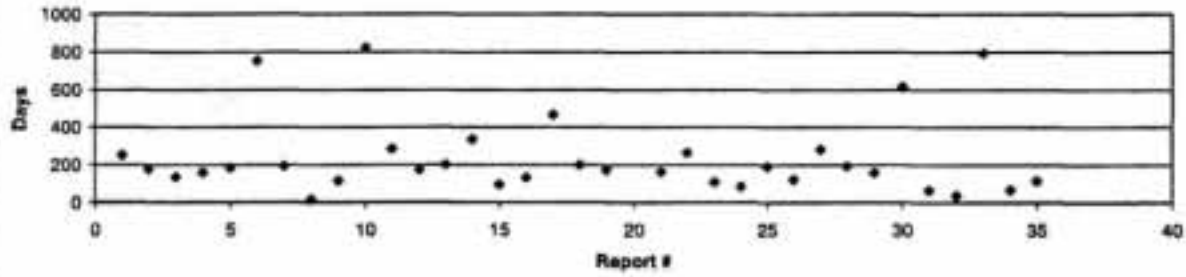


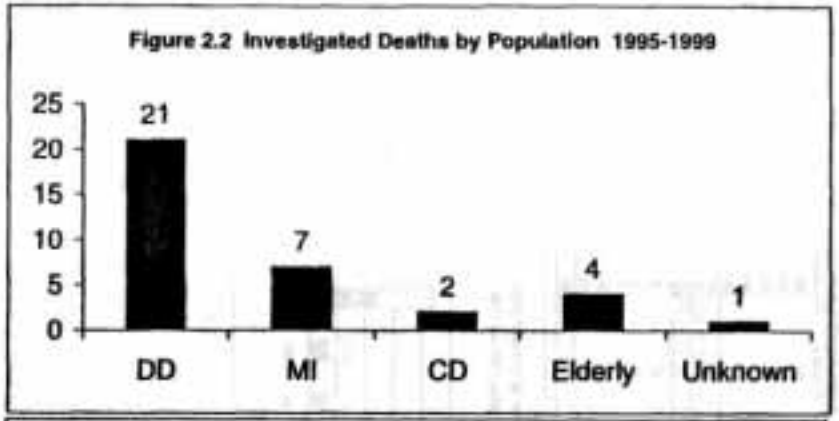

Note: The data on these figures is only for the Rules listed and does not include other rules investigated by OHS, Licensing Division

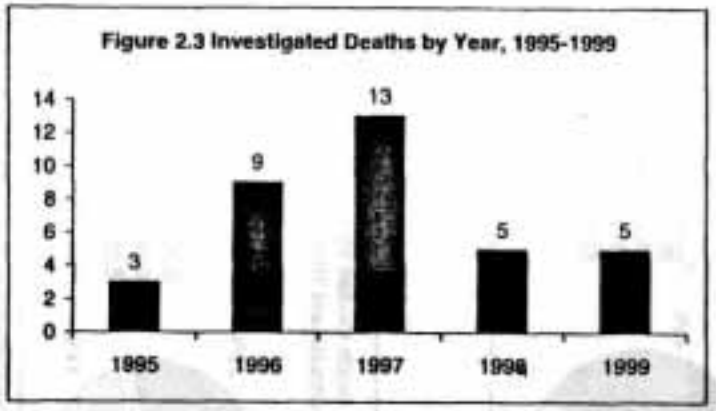
Table 2.1 Deaths investigated by DHS between 1995 and 1999

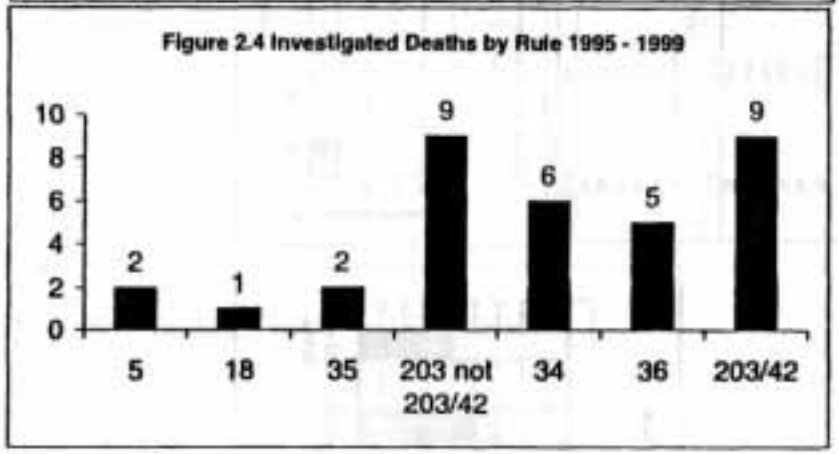
| Report Number | Year | Incident Date | Date of Disp. | Days to Disp. | Disposition | Culpability | Rule | Disability | Maltreatment alleged | Age | Death caused by maltreatment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 70463 | 97 | 11/11/97 | 7/23/98 | 252 | Substantiated maltreatment | Individual | 203 | | Neglect of healthcare | | ? |
| 90209 | 98 | 5/3/98 | 10/29/98 | 178 | Substantiated neglect | P9 & Facility | 34 | DD | MOMA - Failure to protect | 8 | ? |
| 90262 | 98 | 6/12/98 | 10/29/98 | 137 | Substantiated neglect | PI | 34 | DD | MOMA - Failure to protect | 15 | Not Determined |
| 50443 | 95 | 7/10/95 | 12/21/95 | 161 | Substantiated neglect | Facility | 34 | DD | Neglect of supervision | | Not Determined |
| 50715 | 95 | 11/28/95 | 6/3/96 | 185 | Substantiated neglect | Facility | 34 | DD | Neglect of health care | | Not Determined |
| 70095 | 96 | 8/7/96 | 9/10/98 | 753 | Substantiated neglect | Staff | 35 | CD | Neglect of supervision, health care | | Not Determined |
| 50400 | 95 | 5/16/95 | 11/30/95 | 194 | Substantiated neglect | AP1 & 2 | 36 | MI | Neglect of supervision | | Not Determined |
| 70036 | 97 | 2/3/97 | 2/19/97 | 16 | Substantiated neglect | SP | 203 | DD | Neglect of health care | 34 | Not Determined |
| 60073 | 96 | 1/27/96 | 5/21/96 | 114 | Substantiated neglect | HP1& 2 | 203 | elderly | Neglect of health care | | Not Determined |
| 70186 | 96 | 2/15/96 | 5/28/98 | 823 | Substantiated neglect | Staff | 203/42 | DD | Failure to provide health care | | Not Determined |
| 70060 | 97 | 2/21/97 | 12/5/97 | 285 | Substantiated neglect | Staff | 203/42 | DD | Neglect of health care | | Yes |
| 50470 | 96 | 11/1/96 | 4/23/97 | 172 | Substantiated neglect | SP & Facility | 203/42 | DD | Neglect of supervision | | Yes |
| 70198 | 97 | 6/16/97 | 1/8/98 | 202 | Substantiated neglect | Staff | 203/42 | DD | Neglect of supervision | | Yes |
| 80055 | 98 | 1/31/98 | 1/7/99 | 337 | Substantiated neglect | Facility | 203/42 | DD | Neglect of supervision/Failure to provide healthcare | 30 | Yes |
| 90017 | 99 | 1/11/99 | 4/15/99 | 94 | Inconclusive | | 18 | DD | Neglect of supervision, health care | 66 | |
| 90136 | 99 | 2/18/99 | 6/30/99 | 132 | Inconclusive | | 203 | DD | Neglect | 36 | |
| 70065 | 97 | 2/13/97 | 5/29/98 | 466 | Inconclusive | | 203/42 | DD | Neglect of healthcare | | |
| 50356 | 96 | 8/16/96 | 3/6/97 | 200 | Not determined | | 5 | MI | Failure to protect a child from conditions which endanger health | | |
| 90487 | 98 | 9/10/98 | 3/2/99 | 172 | Not determined | | 5 | MI | Neglect, child endangerment | 16 | |
| 90433 | 98 | 9/14/98 | pending | | pending | | 203/42 | DD | Neglect of supervision, health care | 50 | |
| 70228 | 97 | 5/18/97 | 10/31/97 | 163 | FALSE | | 34 | DD | Neglect of supervision | | |
| 70244 | 97 | 6/15/97 | 3/10/98 | 265 | FALSE | | 34 | DD | Neglect of supervision/health care | | |
| 50249 | 96 | 6/11/96 | 9/30/96 | 109 | FALSE | | 35 | CD | Neglect of healthcare | | |
| 90381 | 99 | 7/17/99 | 10/12/99 | 85 | FALSE | | 36 | MI | Neglect of supervision/physical abuse | 61 | |
| 60166 | 96 | 4/10/96 | 10/21/96 | 191 | FALSE | | 36 | MI | Neglect of healthcare | | |
| 70051 | 97 | 1/8/97 | 5/12/97 | 124 | FALSE | | 36 | MI | Neglect | | |
| 70406 | 97 | 10/5/97 | 7/22/98 | 284 | FALSE | | 36 | MI | Neglect of supervision | | |
| 60170 | 96 | 4/16/96 | 10/30/96 | 194 | FALSE | | 203 | DD | Physical | | |
| 70041 | 97 | 2/2/97 | 7/11/97 | 159 | FALSE | | 203 | DD | Neglect of medical care | | |
| 94468 | 97 | 3/1/97 | 11/18/98 | 617 | FALSE | | 203 | elderly | Neglect of health care | 73 | |
| 70272 | 97 | 7/22/97 | 9/26/97 | 64 | FALSE | | 203 | elderly | Neglect of medical care | | |
| 90207 | 99 | 4/22/99 | 5/31/99 | 39 | FALSE | | 203 | elderly | Neglect of health care | 92 | |
| 90039 | 97 | 2/1/97 | 4/14/99 | 793 | FALSE | | 203/42 | DD | Neglect of healthcare | 46 | |
| 90439 | 99 | 8/2/99 | 10/11/99 | 69 | FALSE | | 203/42 | DD | Neglect of supervision | 56 | |
| 90107 | 96 | 1/7/96 | 5/3/96 | 116 | FALSE | | 203/42 | DD/MI | Neglect of health care | | |
| Average | | | | 240 | | | | | | 45 | |

**Figure 2.1 Days to disposition**





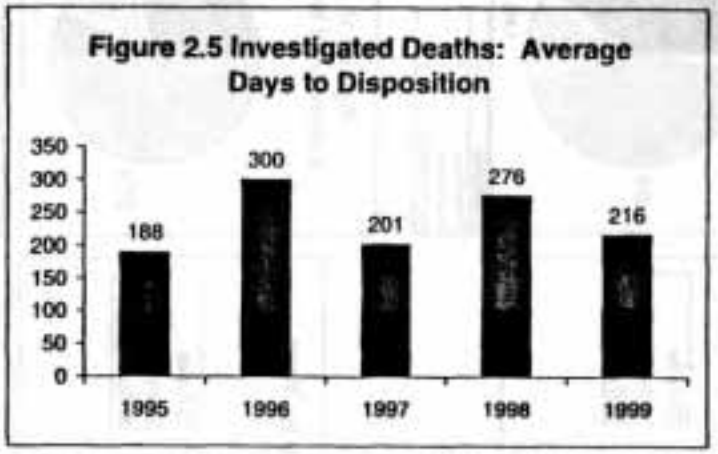
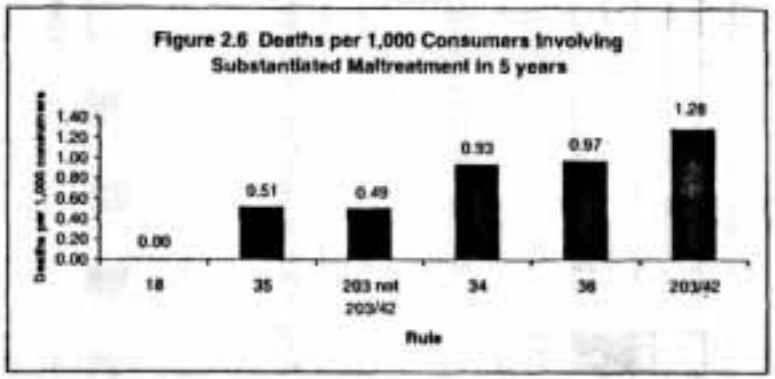
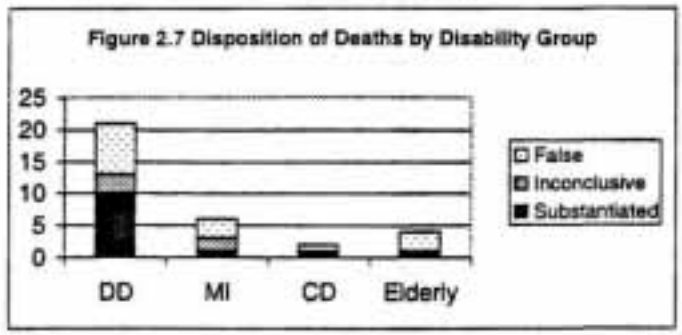




Table 2.2 Five Year Rates of Questionable Deaths Investigated/Substantiated per 1,000 Consumers Served

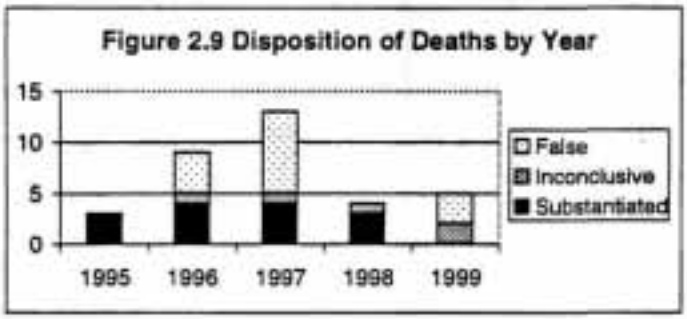
| Rule | Deaths | Average N Consumers | Investigated Rate | Number Substantiated | Substantiated Rate 5 year | Substantiated Rate 1 year |
|---|---|---|---|---|---|---|
| 5 | 2 | | | 0 | 0.00 | 0.000 |
| 18 | 1 | 1,410 | 0.71 | 0 | 0.00 | 0.000 |
| 35 | 2 | 1,972 | 1.01 | 1 | 0.51 | 0.101 |
| 203 not 203/42 | 9 | 6,085 | 1.48 | 3 | 0.49 | 0.099 |
| 34 | 6 | 4,284 | 1.40 | 4 | 0.93 | 0.187 |
| 36 | 5 | 1,030 | 4.85 | 1 | 0.97 | 0.194 |
| 203/42 | 9 | 3,892 | 2.31 | 5 | 1.28 | 0.257 |



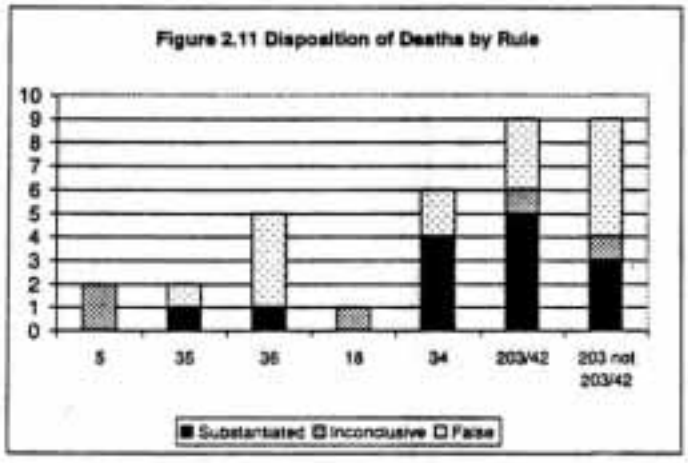
| Group | False | Inconclusive | Substantiated | % Substantiated |
|---|---|---|---|---|
| DD | 8 | 3 | 10 | 47.83% |
| MI | 3 | 2 | 1 | 16.67% |
| CD | 1 | 0 | 1 | 50.00% |
| Elderly | 3 | 0 | 1 | 25.00% |



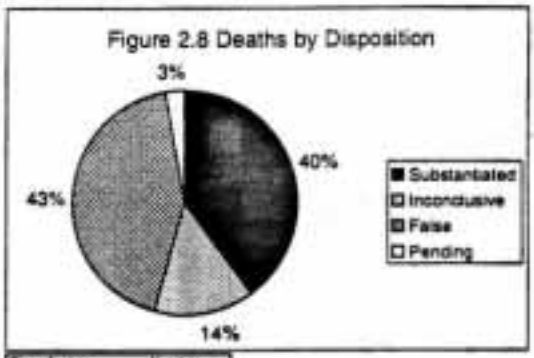

| Year | False | Inconclusive | Substantiated | % Substantiated |
|---|---|---|---|---|
| 1995 | 0 | 0 | 3 | 100.00% |
| 1996 | 4 | 1 | 4 | 44.44% |
| 1997 | 8 | 1 | 4 | 30.77% |
| 1998 | 0 | 1 | 3 | 75.00% |
| 1999 | 3 | 2 | 0 | 0.00% |




| Rule | False | Inconclusive | Substantiated | % Substantiated |
|---|---|---|---|---|
| 5 | 0 | 2 | 0 | 0.00% |
| 35 | 1 | 0 | 1 | 50.00% |
| 36 | 4 | 0 | 1 | 20.00% |
| 18 | 0 | 1 | 0 | 0.00% |
| 34 | 2 | 0 | 4 | 66.67% |
| 203/42 | 3 | 1 | 5 | 55.56% |
| 203 not 203/42 | 5 | 1 | 3 | 33.33% |




| Disposition | Deaths |
|---|---|
| Substantiated | 14 |
| Inconclusive | 5 |
| False | 15 |
| Pending | 1 |




| Classification | Number |
|---|---|
| Preventable | 4 |
| Inconclusive | 2 |
| Not Determined | 8 |

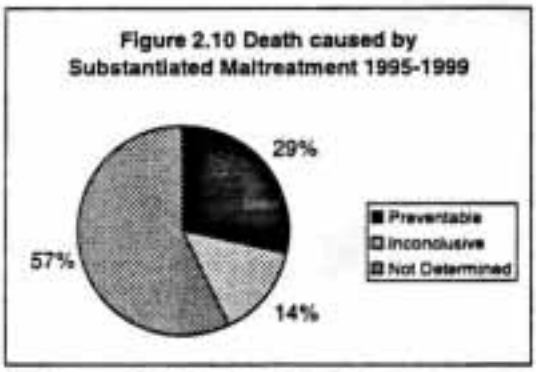



Table 2.3 Nursing Home Deaths Investigated

| | Cases Resulting in Death | | | |
|---|---|---|---|---|
| FY | Cases | # Deaths | Not Death | % Deaths |
| 95 | 423 | 54 | 369 | 13% |
| 96 | 536 | 58 | 478 | 11% |
| 97 | 360 | 42 | 318 | 12% |
| 98 | 340 | 33 | 307 | 10% |
| 99 | 428 | 30 | 398 | 7% |
| Total | 2087 | 217 | 1870 | 10% |

| | Disposition of Cases Resulting in Death | | | |
|---|---|---|---|---|
| FY | Substantiated | Unsubstantiated | Total | % Substantiated |
| 95 | 6 | 3 | 9 | 67% |
| 96 | 0 | 0 | 0 | |
| 97 | 6 | 1 | 7 | 86% |
| 98 | 8 | 6 | 14 | 42% |
| 99 | 8 | 6 | 14 | 43% |
| Total | 24 | 20 | 44 | 55% |

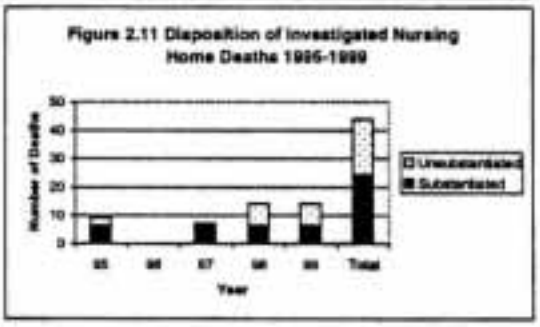
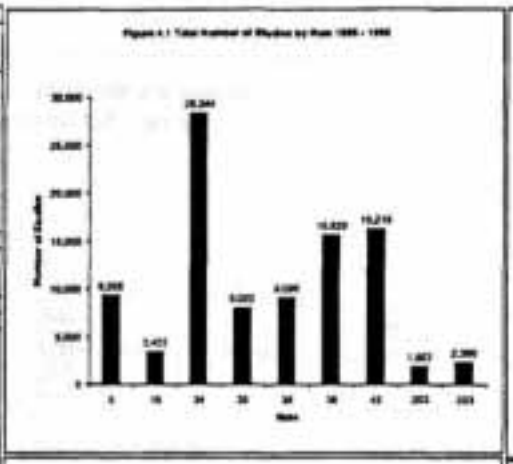
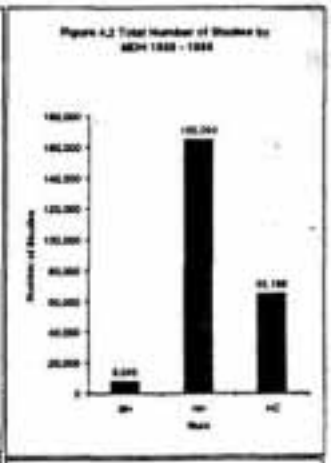
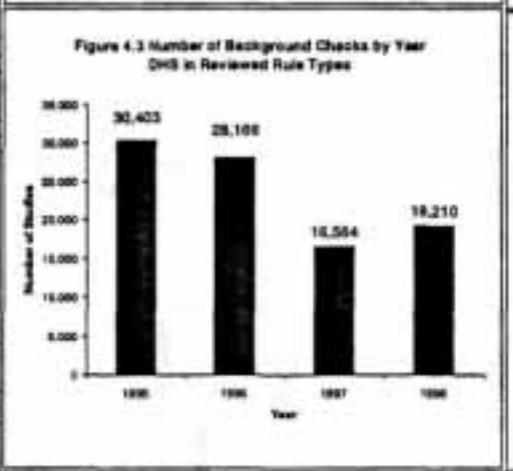


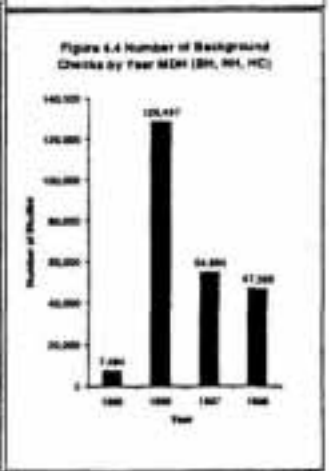
Table 4.1 Disqualifications from Background Checks 1995-1998

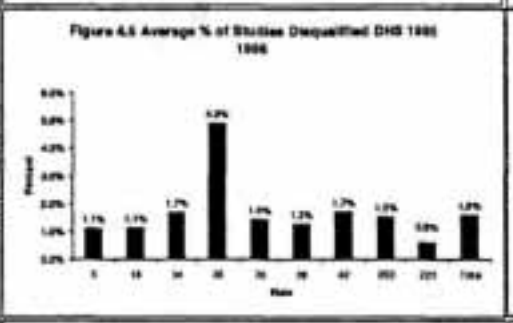
| | Disposition of Studies | | | | |
|---|---|---|---|---|---|
| Rule | DH | Disqualification pmts | Total | | Percent Disqualified |
| **1995** | | | | | |
| 5 | 1,909 | 29 | 1 | 1,939 | 1.5% |
| 15 | 521 | 10 | 0 | 531 | 1.9% |
| 34 | 6,514 | 130 | 10 | 6,644 | 2.1% |
| 35 | 1,561 | 112 | 8 | 1,681 | 6.7% |
| 36 | 1,211 | 31 | 1 | 1,243 | 2.5% |
| 38 | 3,000 | 75 | 3 | 3,078 | 2.4% |
| 42 | 5,617 | 88 | 6 | 5,711 | 2.3% |
| 203 | 963 | 18 | 1 | 970 | 1.9% |
| 223 | 407 | 3 | 1 | 413 | 1.2% |
| DHS Total | 18,693 | 462 | 34 | 19,210 | 2.5% |
| BH | 2,586 | 75 | 0 | 2,641 | 2.8% |
| NH | 28,774 | 824 | 49 | 30,457 | 2.1% |
| HC | 13,875 | 295 | 28 | 14,297 | 2.7% |
| DH Total | 45,210 | 1,096 | 77 | 47,305 | 2.3% |
| Total | 94,512 | 1,558 | 111 | 96,805 | 2.4% |
| **1997** | | | | | |
| 5 | 1,703 | 14 | 2 | 1,719 | 0.8% |
| 15 | 838 | 10 | 1 | 848 | 1.8% |
| 34 | 5,087 | 119 | 10 | 5,216 | 2.3% |
| 35 | 1,454 | 104 | 4 | 1,562 | 6.7% |
| 36 | 1,410 | 22 | 6 | 1,438 | 1.5% |
| 38 | 2,834 | 56 | 4 | 2,874 | 2.1% |
| 42 | 2,584 | 76 | 11 | 2,673 | 2.9% |
| 203 | 7 | 1 | 1 | 9 | 11.1% |
| 223 | 425 | 2 | 0 | 427 | 0.5% |
| DHS Total | 16,109 | 418 | 39 | 16,884 | 2.5% |
| BH | 2,930 | 60 | 1 | 2,999 | 2.3% |
| NH | 33,875 | 778 | 49 | 34,400 | 2.3% |
| HC | 17,072 | 481 | 12 | 17,565 | 2.7% |
| DH Total | 53,877 | 1,225 | 82 | 54,964 | 2.4% |
| Total | 69,986 | 1,741 | 101 | 71,928 | 2.4% |
| **1998** | | | | | |
| 5 | 2,820 | 19 | 0 | 2,842 | 0.7% |
| 15 | 1,031 | 7 | 1 | 1,039 | 0.7% |
| 34 | 7,740 | 110 | 8 | 7,858 | 1.4% |
| 35 | 2,311 | 82 | 3 | 2,396 | 3.4% |
| 36 | 3,221 | 29 | 3 | 3,253 | 0.8% |
| 38 | 5,335 | 33 | 2 | 5,368 | 0.6% |
| 42 | 4,360 | 66 | 8 | 4,434 | 1.5% |
| 203 | 256 | 7 | 1 | 263 | 2.4% |
| 223 | 661 | 2 | 0 | 663 | 0.3% |
| DHS Total | 27,785 | 354 | 28 | 28,188 | 1.3% |
| BH | 2,842 | 20 | 0 | 2,862 | 0.8% |
| NH | 94,179 | 894 | 41 | 94,914 | 0.7% |
| HC | 30,788 | 433 | 20 | 31,221 | 1.4% |
| DH Total | 127,209 | 1,147 | 81 | 128,427 | 0.9% |
| Total | 155,074 | 1,822 | 87 | 156,962 | 1.2% |
| **1999** | | | | | |
| 5 | 2,793 | 42 | 3 | 2,835 | 1.5% |
| 15 | 1,227 | 12 | 0 | 1,239 | 1.0% |
| 34 | 9,492 | 125 | 5 | 9,626 | 1.3% |
| 35 | 2,290 | 98 | 7 | 2,395 | 4.0% |
| 36 | 3,110 | 48 | 4 | 3,162 | 1.5% |
| 38 | 4,282 | 35 | 2 | 4,319 | 0.8% |
| 42 | 5,352 | 49 | 0 | 5,401 | 0.9% |
| 203 | 929 | 8 | 1 | 938 | 0.8% |
| 223 | 936 | 6 | 0 | 943 | 0.6% |
| DHS Total | 29,573 | 411 | 19 | 30,452 | 1.4% |
| BH | 43 | 0 | 0 | 43 | 0.0% |
| NH | 5,292 | 98 | 0 | 5,388 | 0.7% |
| HC | 2,096 | 17 | 1 | 2,113 | 0.8% |
| DH Total | 7,430 | 83 | 1 | 7,484 | 0.7% |
| Total | 37,403 | 494 | 20 | 37,887 | 1.2% |
| **Sum** | | | | | |
| 5 | 9,156 | 104 | 3 | 9,305 | 1.1% |
| 15 | 3,414 | 39 | 2 | 3,455 | 1.1% |
| 34 | 27,885 | 478 | 33 | 28,344 | 1.7% |
| 35 | 7,606 | 394 | 22 | 8,022 | 4.9% |
| 36 | 8,952 | 130 | 14 | 9,096 | 1.4% |
| 38 | 15,410 | 199 | 11 | 15,620 | 1.3% |
| 42 | 16,913 | 278 | 25 | 16,219 | 1.7% |
| 203 | 1,874 | 33 | 4 | 1,907 | 1.8% |
| 223 | 3,351 | 14 | 1 | 3,366 | 0.6% |
| DHS Total | 82,580 | 1,668 | 116 | 84,343 | 1.8% |
| BH | 7,881 | 163 | 1 | 8,045 | 2.0% |
| NH | 162,800 | 2,140 | 139 | 165,099 | 1.3% |
| HC | 63,814 | 1,321 | 61 | 65,196 | 2.0% |
| DH Total | 234,515 | 3,624 | 201 | 238,340 | 1.5% |
| Total | 317,075 | 5,299 | 315 | 322,683 | 1.6% |
| **Average** | | | | | |
| 5 | 2,300 | 26 | 1 | 2,326 | 1.1% |
| 15 | 854 | 10 | 1 | 864 | 1.1% |
| 34 | 6,958 | 120 | 8 | 7,086 | 1.7% |
| 35 | 1,902 | 99 | 6 | 2,006 | 4.9% |
| 36 | 2,238 | 33 | 4 | 2,274 | 1.4% |
| 38 | 3,858 | 50 | 3 | 3,907 | 1.3% |
| 42 | 3,978 | 70 | 7 | 4,056 | 1.7% |
| 203 | 469 | 7 | 1 | 477 | 1.5% |
| 223 | 588 | 4 | 0 | 592 | 0.6% |
| DHS Total | 22,140 | 418 | 30 | 22,588 | 1.8% |
| BH | 1,970 | 41 | 0 | 2,011 | 2.0% |
| NH | 40,705 | 535 | 35 | 41,275 | 1.3% |
| HC | 15,954 | 330 | 15 | 16,299 | 2.0% |
| DH Total | 58,622 | 906 | 50 | 59,585 | 1.5% |
| Total | 81,790 | 1,322 | 80 | 82,171 | 1.6% |

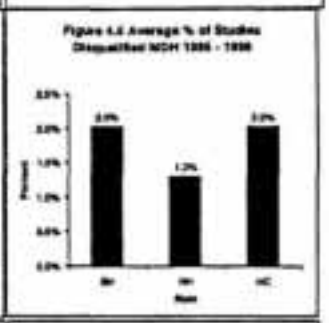


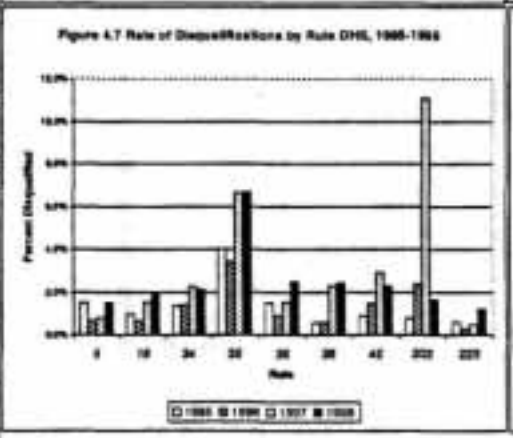


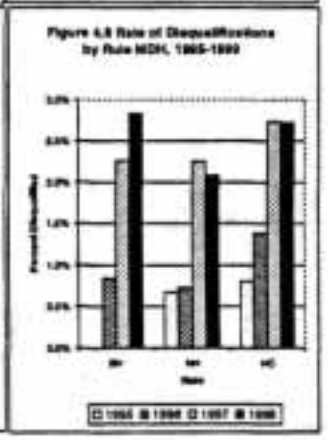



Note: These tables and figures do not represent all background studies conducted, only those in the Hubbard license types.

Table 4.2 Reasons for Disqualification 1995 to 1999

| Rule | Failure to cooperate | Maltreatment | Crime | Total DQC | # Fingerprints required | % Due to Maltreatment |
|---|---|---|---|---|---|---|
| **1995** | | | | | | |
| 5 | 24 | 2 | 20 | 46 | 63 | 4.3% |
| 18 | 4 | 1 | 4 | 9 | 5 | 11.1% |
| 34 | 56 | 22 | 89 | 191 | 35 | 11.5% |
| 35 | 72 | 9 | 110 | 37 | 75 | 24.3% |
| 36 | 15 | 2 | 20 | 96 | 20 | 2.1% |
| 38 | 44 | 4 | 48 | 96 | 39 | 4.2% |
| 42 | 30 | 17 | 49 | 39 | 36 | 43.6% |
| 203 | 10 | 4 | 9 | 23 | 10 | 17.4% |
| 223 | 4 | 0 | 3 | 7 | 10 | 0.0% |
| BH | 49 | 0 | 40 | 40 | 31 | 0.0% |
| NH | 327 | 29 | 306 | 306 | 336 | 9.5% |
| HC | 240 | 15 | 207 | 462 | 176 | 3.2% |
| Total | 875 | 105 | 905 | 1,352 | 283 | 7.8% |
| **1997** | | | | | | |
| 5 | 5 | 1 | 11 | 17 | 9 | 5.9% |
| 18 | 1 | 1 | 6 | 8 | 8 | 12.5% |
| 34 | 51 | 13 | 48 | 142 | 61 | 9.2% |
| 35 | 50 | 1 | 79 | 131 | 63 | 0.8% |
| 36 | 11 | 2 | 8 | 21 | 13 | 9.5% |
| 38 | 39 | 4 | 45 | 88 | 38 | 4.5% |
| 42 | 34 | 19 | 45 | 98 | 40 | 19.4% |
| 203 | 1 | 0 | 0 | 1 | 1 | 0.0% |
| 223 | 1 | 0 | 0 | 1 | 1 | 0.0% |
| BH | 30 | 2 | 27 | 59 | 23 | 3.4% |
| NH | 318 | 42 | 381 | 741 | 447 | 5.7% |
| HC | 233 | 11 | 294 | 538 | 253 | 2.0% |
| Total | 774 | 96 | 944 | 1,845 | 957 | 5.2% |
| **1996** | | | | | | |
| 5 | 5 | 3 | 16 | 24 | 13 | 12.5% |
| 18 | 1 | 3 | 3 | 7 | 2 | 42.9% |
| 34 | 41 | 17 | 89 | 147 | 61 | 11.6% |
| 35 | 30 | 4 | 91 | 125 | 64 | 3.2% |
| 36 | 11 | 3 | 19 | 33 | 22 | 9.1% |
| 38 | 12 | 7 | 22 | 41 | 31 | 17.1% |
| 42 | 18 | 23 | 51 | 92 | 25 | 25.0% |
| 203 | 1 | 4 | 2 | 7 | 2 | 57.1% |
| 223 | 3 | 0 | 4 | 7 | 2 | 0.0% |
| BH | 12 | 0 | 19 | 31 | 17 | 0.0% |
| NH | 341 | 16 | 695 | 1,052 | 620 | 1.5% |
| HC | 210 | 8 | 436 | 654 | 270 | 1.2% |
| Total | 685 | 88 | 1,447 | 2,220 | 1,129 | 4.0% |
| **1998** | | | | | | |
| 5 | 8 | 5 | 15 | 28 | 17 | 17.9% |
| 18 | 2 | 0 | 1 | 3 | 4 | 0.0% |
| 34 | 32 | 9 | 97 | 138 | 64 | 6.5% |
| 35 | 20 | 6 | 68 | 94 | 52 | 6.4% |
| 36 | 8 | 1 | 36 | 45 | 32 | 2.2% |
| 38 | 5 | 2 | 18 | 25 | 24 | 8.0% |
| 42 | 7 | 1 | 36 | 44 | 23 | 2.3% |
| 203 | 1 | 0 | 3 | 4 | 6 | 0.0% |
| 223 | 1 | 0 | 4 | 5 | 9 | 0.0% |
| BH | 0 | 0 | 5 | 5 | 2 | 0.0% |
| NH | 12 | 0 | 71 | 83 | 53 | 0.0% |
| HC | 6 | 0 | 40 | 46 | 34 | 0.0% |
| Total | 102 | 24 | 394 | 520 | 320 | 4.6% |
| **Sum** | | | | | | |
| 5 | 42 | 11 | 62 | 115 | 102 | 9.6% |
| 18 | 8 | 5 | 14 | 27 | 19 | 18.5% |
| 34 | 180 | 61 | 323 | 618 | 221 | 9.9% |
| 35 | 172 | 20 | 348 | 387 | 254 | 5.2% |
| 36 | 45 | 8 | 83 | 195 | 87 | 4.1% |
| 38 | 100 | 17 | 133 | 250 | 132 | 6.8% |
| 42 | 89 | 60 | 181 | 273 | 124 | 22.0% |
| 203 | 13 | 8 | 14 | 35 | 19 | 22.9% |
| 223 | 9 | 0 | 11 | 20 | 22 | 0.0% |
| BH | 91 | 2 | 91 | 135 | 73 | 1.5% |
| NH | 998 | 87 | 1,453 | 2,182 | 1,456 | 4.0% |
| HC | 689 | 34 | 977 | 1,700 | 733 | 2.0% |
| Total | 2,436 | 313 | 3,690 | 5,937 | 2,889 | 5.3% |

**Figure 4.9 Reasons for Disqualifications by Year for Reviewed Rule Types**

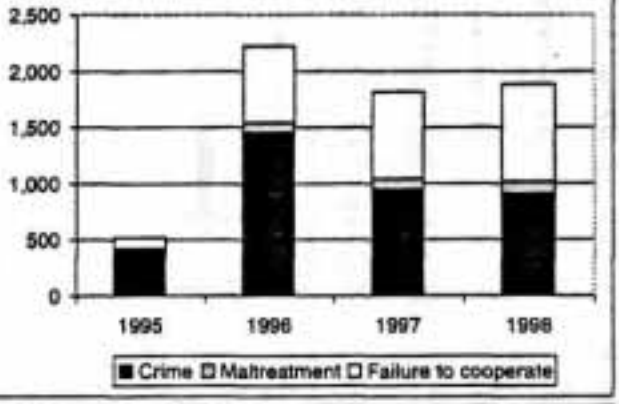



**Figure 4.10 Percent DQ Due to Prior Maltreatment 1995-1998**

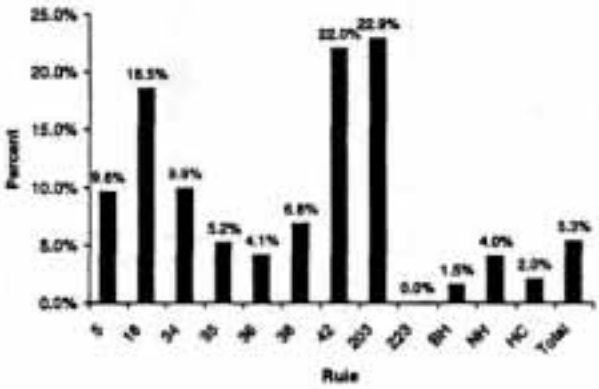



**Figure 4.11 Number of DQ Due to Maltreatment 1995-1998**

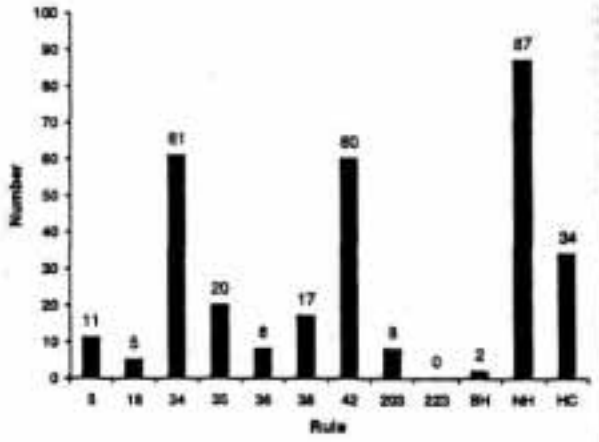


Table 3.1 Background Study Reconsiderations, Variances and Overturned 1995 to 1999

| | Number of Reconsiderations and Variances | | | | | | Disposition of Studies | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area | Reconsid. Denied | Reconsid. Granted | % Reconsid. Granted | Variances Denied | Variances Granted | % Variances Granted | OK | Disqualification | proc | Total | % Disq Reconsidered | % Disq Set Aside | % Studies Set Aside |
| **1995** | | | | | | | | | | | | | |
| 5 | 2 | 7 | 78% | 0 | 3 | 100% | 1,908 | 29 | 1 | 1,939 | 31% | 24% | 0.30% |
| 18 | 3 | 1 | 25% | 0 | 0 | | 521 | 10 | 0 | 531 | 40% | 10% | 0.19% |
| 34 | 18 | 30 | 65% | 1 | 1 | 50% | 5,514 | 120 | 10 | 5,644 | 38% | 25% | 0.53% |
| 35 | 6 | 24 | 75% | 0 | 1 | 100% | 1,561 | 113 | 8 | 1,681 | 20% | 21% | 1.43% |
| 36 | 3 | 5 | 63% | 1 | 0 | 0% | 1,211 | 31 | 1 | 1,243 | 26% | 16% | 0.40% |
| 38 | 7 | 16 | 70% | 0 | 0 | | 3,060 | 75 | 3 | 3,078 | 26% | 21% | 0.62% |
| 42 | 7 | 18 | 72% | 0 | 1 | 100% | 3,617 | 85 | 9 | 3,711 | 20% | 21% | 0.48% |
| 203 | 4 | 2 | 33% | 0 | 0 | | 863 | 16 | 1 | 970 | 38% | 13% | 0.21% |
| 223 | 1 | 1 | 50% | 0 | 0 | | 407 | 5 | 1 | 413 | 40% | 20% | 0.24% |
| BH | 3 | 16 | 84% | 0 | 2 | 100% | 2,566 | 75 | 0 | 2,641 | 25% | 21% | 0.81% |
| MH | 25 | 141 | 85% | 0 | 8 | 100% | 29,774 | 634 | 49 | 30,457 | 28% | 22% | 0.46% |
| HC | 28 | 56 | 86% | 1 | 11 | 92% | 13,879 | 300 | 28 | 14,207 | 21% | 14% | 0.38% |
| Total | 107 | 319 | 75% | 3 | 26 | 90% | 64,912 | 1,542 | 111 | 66,936 | 27% | 20% | 0.48% |
| **1997** | | | | | | | | | | | | | |
| 5 | 3 | 4 | 57% | 1 | 1 | 50% | 1,703 | 14 | 2 | 1,719 | 50% | 29% | 0.23% |
| 18 | 0 | 2 | 100% | 0 | 0 | | 836 | 10 | 1 | 846 | 30% | 20% | 0.31% |
| 34 | 6 | 33 | 80% | 0 | 5 | 100% | 5,087 | 118 | 10 | 5,218 | 34% | 28% | 0.63% |
| 35 | 10 | 27 | 73% | 0 | 2 | 100% | 1,454 | 104 | 4 | 1,562 | 38% | 26% | 1.73% |
| 36 | 2 | 7 | 78% | 0 | 5 | 100% | 1,410 | 22 | 6 | 1,438 | 41% | 32% | 0.48% |
| 38 | 2 | 11 | 85% | 0 | 2 | 100% | 2,804 | 66 | 4 | 2,874 | 20% | 17% | 0.38% |
| 42 | 6 | 18 | 75% | 0 | 0 | | 2,584 | 78 | 11 | 2,673 | 35% | 24% | 0.71% |
| 203 | 0 | 0 | | 0 | 0 | | 7 | 1 | 1 | 8 | 0% | 0% | 0.00% |
| 223 | 0 | 1 | 100% | 0 | 0 | | 425 | 2 | 0 | 427 | 50% | 50% | 0.23% |
| BH | 2 | 8 | 80% | 0 | 1 | 100% | 2,930 | 68 | 1 | 2,999 | 15% | 12% | 0.27% |
| MH | 28 | 202 | 87% | 0 | 8 | 100% | 33,575 | 776 | 49 | 34,400 | 30% | 26% | 0.58% |
| HC | 25 | 127 | 84% | 0 | 6 | 100% | 17,072 | 481 | 12 | 17,569 | 32% | 26% | 0.72% |
| Total | 88 | 441 | 83% | 1 | 30 | 97% | 66,686 | 1,741 | 101 | 71,529 | 30% | 25% | 0.62% |
| **1996** | | | | | | | | | | | | | |
| 5 | 0 | 5 | 100% | 0 | 0 | | 2,823 | 19 | 0 | 2,842 | 26% | 26% | 0.18% |
| 18 | 0 | 2 | 100% | 0 | 2 | 100% | 1,031 | 7 | 1 | 1,039 | 29% | 29% | 0.19% |
| 34 | 3 | 24 | 89% | 0 | 4 | 100% | 7,740 | 110 | 8 | 7,858 | 25% | 22% | 0.31% |
| 35 | 6 | 28 | 81% | 0 | 2 | 100% | 2,311 | 82 | 3 | 2,396 | 39% | 30% | 1.04% |
| 36 | 3 | 9 | 75% | 0 | 9 | 100% | 3,221 | 29 | 3 | 3,253 | 41% | 31% | 0.28% |
| 38 | 1 | 4 | 80% | 0 | 0 | | 5,333 | 33 | 2 | 5,368 | 15% | 12% | 0.07% |
| 42 | 4 | 10 | 75% | 0 | 1 | 100% | 4,360 | 66 | 8 | 4,434 | 24% | 16% | 0.27% |
| 203 | 0 | 2 | 100% | 0 | 0 | | 280 | 7 | 1 | 293 | 29% | 29% | 0.68% |
| 223 | 0 | 0 | | 0 | 0 | | 881 | 2 | 0 | 883 | 0% | 0% | 0.00% |
| BH | 0 | 5 | 100% | 0 | 0 | | 2,342 | 20 | 0 | 2,362 | 25% | 25% | 0.21% |
| MH | 9 | 253 | 97% | 0 | 22 | 100% | 84,179 | 684 | 41 | 84,914 | 35% | 37% | 0.27% |
| HC | 12 | 140 | 92% | 0 | 9 | 100% | 30,788 | 433 | 20 | 31,221 | 35% | 30% | 0.45% |
| Total | 38 | 483 | 93% | 0 | 49 | 100% | 160,074 | 1,500 | 87 | 161,663 | 35% | 32% | 0.31% |
| **1998** | | | | | | | | | | | | | |
| 5 | 3 | 5 | 63% | 0 | 1 | 100% | 2,783 | 42 | 9 | 2,835 | 19% | 12% | 0.18% |
| 18 | 0 | 3 | 100% | 0 | 0 | | 1,227 | 10 | 0 | 1,238 | 25% | 25% | 0.24% |
| 34 | 8 | 2 | 18% | 1 | 6 | 86% | 9,492 | 129 | 5 | 9,626 | 9% | 2% | 0.02% |
| 35 | 7 | 18 | 72% | 1 | 3 | 83% | 2,280 | 96 | 7 | 2,383 | 35% | 16% | 0.76% |
| 36 | 1 | 6 | 86% | 1 | 3 | 75% | 3,110 | 46 | 4 | 3,162 | 15% | 13% | 0.18% |
| 38 | 0 | 4 | 100% | 0 | 2 | 100% | 4,282 | 25 | 2 | 4,308 | 15% | 16% | 0.09% |
| 42 | 1 | 2 | 67% | 0 | 1 | 100% | 5,352 | 48 | 3 | 5,401 | 9% | 4% | 0.04% |
| 203 | 0 | 0 | | 0 | 0 | | 629 | 5 | 1 | 635 | 0% | 0% | 0.00% |
| 223 | 0 | 1 | 100% | 0 | 0 | | 836 | 6 | 3 | 843 | 20% | 20% | 0.12% |
| BH | 0 | 0 | | 0 | 0 | | 43 | 0 | 0 | 43 | | | 0.00% |
| MH | 0 | 3 | 100% | 0 | 0 | | 5,292 | 36 | 0 | 5,328 | 6% | 6% | 0.04% |
| HC | 1 | 0 | 0% | 0 | 0 | | 2,095 | 17 | 1 | 2,113 | 0% | 0% | 0.00% |
| Total | 22 | 44 | 67% | 3 | 20 | 87% | 37,403 | 464 | 20 | 37,887 | 14% | 9% | 0.12% |
| **Sum** | | | | | | | | | | | | | |
| 5 | 8 | 21 | 72% | 1 | 4 | 80% | 9,196 | 104 | 3 | 9,305 | 28% | 20% | 0.23% |
| 18 | 3 | 8 | 73% | 0 | 2 | 100% | 3,414 | 39 | 2 | 3,455 | 29% | 21% | 0.23% |
| 34 | 36 | 89 | 71% | 2 | 15 | 90% | 27,833 | 478 | 33 | 28,344 | 26% | 19% | 0.31% |
| 35 | 31 | 94 | 75% | 1 | 10 | 91% | 7,606 | 384 | 22 | 8,022 | 32% | 24% | 1.17% |
| 36 | 9 | 27 | 75% | 2 | 20 | 91% | 8,952 | 130 | 14 | 9,096 | 26% | 21% | 0.30% |
| 38 | 10 | 38 | 79% | 0 | 4 | 100% | 15,419 | 199 | 11 | 15,629 | 24% | 18% | 0.24% |
| 42 | 20 | 51 | 72% | 0 | 3 | 100% | 15,913 | 278 | 28 | 16,219 | 25% | 18% | 0.31% |
| 203 | 4 | 4 | 50% | 0 | 0 | | 1,874 | 29 | 4 | 1,907 | 25% | 14% | 0.21% |
| 223 | 1 | 3 | 75% | 0 | 0 | | 2,351 | 14 | 1 | 2,366 | 20% | 21% | 0.13% |
| BH | 5 | 29 | 85% | 0 | 3 | 100% | 7,681 | 163 | 1 | 8,049 | 21% | 18% | 0.36% |
| MH | 63 | 601 | 91% | 0 | 38 | 100% | 162,820 | 2,143 | 139 | 165,399 | 31% | 28% | 0.36% |
| HC | 66 | 322 | 83% | 1 | 25 | 96% | 63,511 | 1,321 | 67 | 65,199 | 29% | 24% | 0.48% |
| Total | 254 | 1,267 | 83% | 7 | 128 | 95% | 327,075 | 5,288 | 319 | 332,663 | 29% | 24% | 0.39% |
| **Average** | | | | | | | | | | | | | |
| 5 | 2 | 5 | 72% | 0 | 1 | 80% | 2,300 | 26 | 1 | 2,326 | 28% | 20% | 0.23% |
| 18 | 1 | 2 | 73% | 0 | 1 | 100% | 854 | 10 | 1 | 864 | 25% | 21% | 0.23% |
| 34 | 9 | 22 | 71% | 1 | 5 | 90% | 6,958 | 120 | 8 | 7,086 | 26% | 19% | 0.31% |
| 35 | 8 | 24 | 75% | 0 | 3 | 91% | 1,902 | 96 | 6 | 2,006 | 32% | 24% | 1.17% |
| 36 | 2 | 7 | 75% | 1 | 5 | 91% | 2,238 | 33 | 4 | 2,274 | 26% | 21% | 0.30% |
| 38 | 3 | 10 | 79% | 0 | 1 | 100% | 3,855 | 50 | 3 | 3,907 | 24% | 18% | 0.24% |
| 42 | 5 | 13 | 72% | 0 | 1 | 100% | 3,978 | 70 | 7 | 4,055 | 25% | 18% | 0.31% |
| 203 | 1 | 1 | 50% | 0 | 0 | | 469 | 7 | 1 | 477 | 25% | 14% | 0.21% |
| 223 | 0 | 1 | 75% | 0 | 0 | | 588 | 4 | 0 | 592 | 20% | 21% | 0.13% |
| BH | 1 | 7 | 86% | 0 | 1 | 100% | 1,970 | 41 | 0 | 2,011 | 21% | 18% | 0.36% |
| MH | 16 | 150 | 91% | 0 | 10 | 100% | 40,706 | 536 | 36 | 41,278 | 31% | 28% | 0.36% |
| HC | 17 | 81 | 83% | 0 | 7 | 96% | 15,954 | 330 | 15 | 16,299 | 29% | 24% | 0.48% |
| Total | 64 | 322 | 83% | 2 | 32 | 95% | 81,769 | 1,322 | 82 | 83,171 | 29% | 24% | 0.39% |

as conducted, only those conducted in the eligible license types.

Figure 5.1 Percent of Disqualifications Reconsidered for Reviewed Rule Types

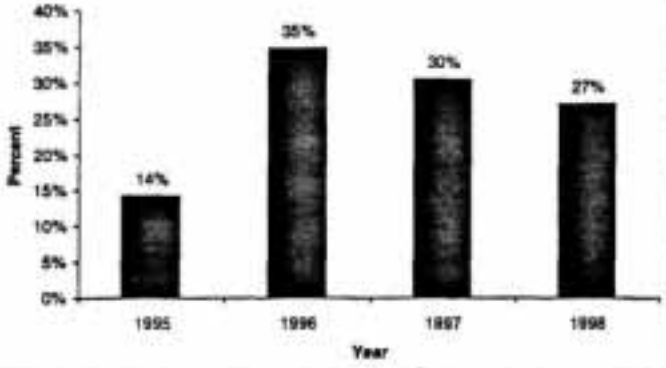



Figure 5.2 Average Percent of Disqualifications Reconsidered 1995-1998

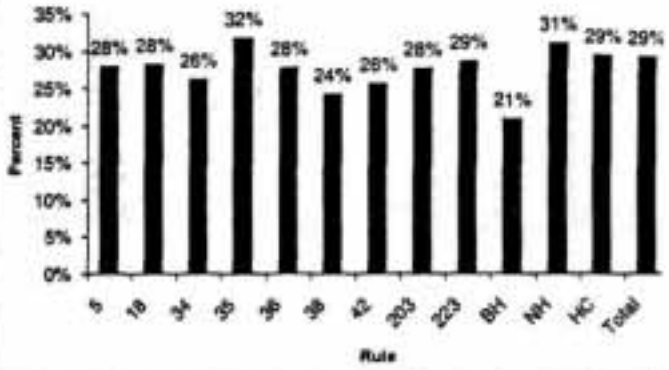



Figure 5.3 Percent of Disqualifications Overturned After Reconsideration for Reviewed Rule Types

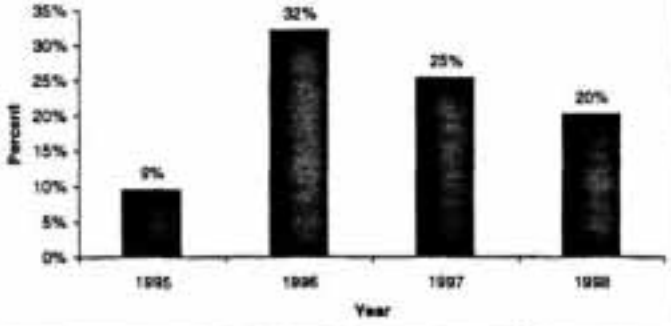



Figure 5.4 Average Percent of All Disqualifications Set Aside 1995-1998

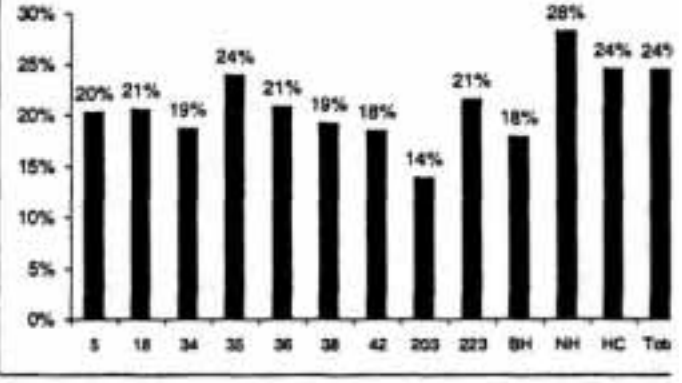



Figure 5.5 Total Number of Reconsiderations Granted for DHS Programs by Rule Between 1995-1998

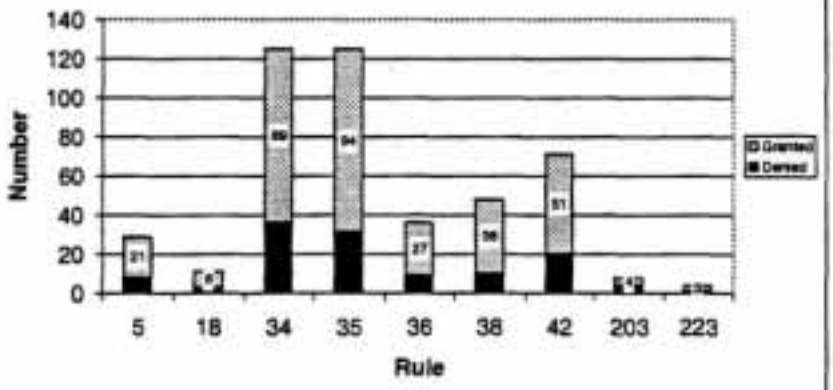



Figure 5.6 Total Number of Reconsiderations Granted in MHD Programs Between 1995-1998